



**Medical Release and Permission Form**

**Student Name:** \_\_\_\_\_

**Church:** \_\_\_\_\_

I hereby certify that \_\_\_\_\_ is in good health and has my permission to participate in all activities related to IGNITE.

**In case of an emergency**, I hereby give permission to the physician selected by IGNITE staff to hospitalize; secure proper treatment for; and order injection, anesthesia, x-rays, or surgery for my child named above.

Parent Name \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_

Work or cell phone (\_\_\_\_) \_\_\_\_\_

Health Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ ID # \_\_\_\_\_

Allergies \_\_\_\_\_

**Media Release Form**

I, \_\_\_\_\_, hereby grant Bethel University the irrevocable right and license to use and edit at their discretion my photograph, video, and/or audio, and to use or authorize its use, or any portion thereof, in any manner or media at this time and/or at any time in the future.

I agree to hold Bethel University and its employees, agents, and successors harmless against any liability, loss, or damage resulting from the use of my image, and hereby release and discharge them from any and all claims whatsoever.

I affirm that I am 18 years of age and am signing this release freely and voluntarily for myself, or I am signing it for the following minor for whom I have responsibility (\_\_\_\_\_).

In executing this release, I do not rely on any inducements, promises, or representations made by Bethel University.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please mail in an envelope to:  
Office of Church Ministries  
Bethel University  
3900 Bethel Drive  
St. Paul, MN 55112