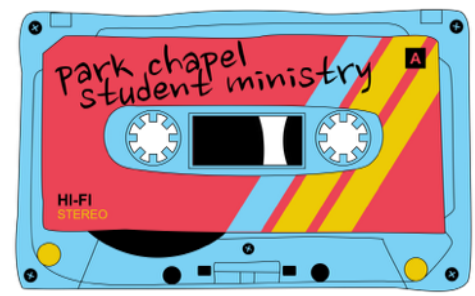


# PARK CHAPEL CHRISTIAN CHURCH STUDENT MINISTRY

## 2017 MEDICAL RELEASE FORM Information, Release Forms & Agreements



### Participant Information:

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Legal Name (First, Middle, Last): \_\_\_\_\_ Preferred name: \_\_\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Grade: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ T-Shirt Size \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone (student): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_

### Parent/Guardian & Emergency Contact Information:

Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_  
(Please circle preferred contact number)

Email Address: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_  
(Please circle preferred contact number)

Email Address: \_\_\_\_\_

Emergency Contact (in case we cannot reach the above)

Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_  
(Please circle preferred contact number)

Email Address: \_\_\_\_\_

Parents or Guardians, please initial on the line by each medication you give permission for us to dispense to your child (upon request) from our emergency supply box. For any medications you initial, you will not have to send a supply of that particular medication.

\_\_\_\_ Ibuprofen (Advil or Motrin) \_\_\_\_ Acetaminophen (Tylenol) \_\_\_\_ Allergy (Claritin, Benadryl) Please initial:

\_\_\_\_ I understand that this is for over the counter medication only. Should my child have other medication, the medication and its instructions will be turned into the nurse upon registration on the departure day.

\_\_\_\_ I understand that if my child begins a medication after this form is turned in changing the information provided above, it is my responsibility to update paperwork on file in the Student Ministry Office and alert them of these changes.

**Medical Information:**

In the unlikely event that we would have to transport your child to the hospital, we need all medical information possible. We will keep these on file in the student ministry office for the 2017 calendar year. **You will be responsible to notify us if your insurance information changes.**

Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Policy/Group Number \_\_\_\_\_

Food Allergies (please name) \_\_\_\_\_

Drug Allergies (please name) \_\_\_\_\_

Last Tetanus Shot: \_\_\_\_--\_\_\_\_--\_\_\_\_

(Please initial) \_\_\_\_ All immunizations are up to date

Check the following **AREAS OF CONCERN** for this student. If necessary, add another page with details.

Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:

\_\_Asthma/ Breathing/Respiratory Issues \_\_Physical Limitations\* \_\_Epilepsy / Seizure Disorder \_\_Cardiac Issues

\_\_Behavioral\*Diabetes \_\_Frequently Upset Stomach/Ulcers \_\_EpiPen \_\_Other \_\_\_\_\_

Has the participant had any major illnesses or injuries during the last year? Yes No

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Should this the participant's activities be restricted for any reason? Yes No

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Medications and dosages must be listed on the Medication Form and turned into the nurse for each event upon student check-in.

**Participant Agreement:**

**Please initial next to each section.**

\_\_ **CELL PHONES** will be allowed on student events. However, if a cell phone becomes a distraction and we will collect it and it will be returned at the end of the event. The Student Ministry and Park Chapel Christian Church are NOT responsible for the well-being of your student's phone. This includes being left, lost or damaged in any way.

\_\_ **THE BIG 3** Any student who brings drugs, alcohol, or any type of weapon will be immediately sent home. In addition, anyone who fights, threatens the safety of others, or fails to comply with event rules will be subject to removal from the event. \_\_ **DISPLAYS OF AFFECTION** between girls and guys are inappropriate and will not be tolerated!

\_\_ **ROOMS ARE PRIVATE.** No Girls in Guys rooms / No Guys in Girls rooms.

\_\_ **"Fab 5" Group Proverbs:**

- Show Respect! • Listen! • Be Flexible! • Have a Good Attitude!

- Be where you're supposed to be, when you're supposed to be there, doing what you're supposed to be doing!

I, the student, have read the above evaluation of my health, and permission to participate in student activities. I agree to abide by the stated personal limitations and code of conduct.

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Permissions and Releases:**

By signing, the participant (and parent/guardian if the participant is a minor) acknowledges that \_\_\_\_\_ has permission to travel with Park Chapel Christian Church or attend all student activities from January 1, 2017 through December 31, 2017.

\_\_\_\_\_parent/guardian initials

I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by the Church. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement.

\_\_\_\_\_parent/guardian initials

This consent form gives permission to seek medical attention as deemed necessary, and releases the Church and its staff of any liability against personal losses of named child. In the event that he/she is injured and requires the attention of a medical provider, I/we consent to any reasonable medical treatment as deemed necessary by a licensed provider. In such an event where treatment is required, from a provider and/or hospital personnel designated by the Church, I/we agree to hold such person(s) free and harmless of any claims, demands, or suits for damages arising from the giving of such consent.

\_\_\_\_\_parent/guardian initials

I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the student ministries staff member

\_\_\_\_\_parent/guardian initials

I/We also give permission to Student Ministries to photograph and/or video tape my child for the promotional purposes of Student Ministries and/or Park Chapel Christian Church.

\_\_\_\_\_parent/guardian initials

**This section must be completed and notarized before submission:**

By signing below, I am agreeing that the information provided above is correct and true to the best of my knowledge.

Name (Print) \_\_\_\_\_ Name (Signature) \_\_\_\_\_ Date: \_\_\_\_\_

STATE OF INDIANA

COUNTY OF \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_, before me personally appeared \_\_\_\_\_, to me known to be the person (or persons) described in and who executed the foregoing instrument, and acknowledged that such person (or persons) executed the same as such person (or person's) free act and deed.

\_\_\_\_\_  
Notary Public Signature

\_\_\_\_\_  
Commission Expires