Event

Medical Release & Permission Form

Effective dates: _____ to _____

Please print in ink

Name: _____ Age _____ Birthdate _____
LAST FIRST MIDDLE

Year in school _____ ❑ Male ❑ Female Email _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Medical insurance company _____ Policy # _____

Mother's name _____ Phone: Home _____ Work _____

Father's name _____ Phone: Home _____ Work _____

Emergency contact _____ Phone: Home _____ Work _____

Physician _____ Office phone _____

Dentist _____ Office phone _____

PARENTAL/GUARDIAN AUTHORIZATION FOR MEDICAL CARE & COVERAGE

I hereby authorize Vision Church Ignite Student Ministry to transport my child to and from a medical facility in the event of unexpected illness or injury. Furthermore, I give permission for the Ignite Student Ministry Coordinator or his designate to allow licensed medical professionals to perform emergency treatment or administer drugs in conjunction with such emergency treatment. I hereby give permission for my child to receive the following over the counter medications as deemed necessary by the Ministry Leaders.

PERMISSION	MEDICATION	PERMISSION	MEDICATION
Y / N	IBUPROFEN	Y / N	COUGH DROPS
Y / N	ACETAMINOPHEN	Y / N	HYDROCORTISONE CREAM
Y / N	BENADRYL	Y / N	CHLORASEPTIC SPRAY
Y / N	CHILDREN'S PEPTO-BISMOL	Y / N	MAALOX/ MILK OF MYLANTA
Y / N	OTHER_____	Y / N	OTHER_____

Medical History

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. Include names of medications and dosages that must be taken on the separate Medication Log form.

Check the following areas of concern for this student. If necessary, add another page with details:

1. For your child's safety and our knowledge, is your student a —

   ❑ good swimmer ❑ fair swimmer ❑ non-swimmer

2. Does your child have allergies to—

   ❑ pollens ❑ medications ❑ food ❑ insect bites

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

   ❑ asthma ❑ epilepsy / seizure disorder ❑ heart trouble ❑ diabetes

   ❑ frequently upset stomach ❑ physical handicap

4. Date of last tetanus shot: _____

5. Does your child wear ❑ glasses ❑ contact lenses

6. Please list and explain any major illnesses the child experienced during the last year:

   Additional comments:

   Should this child's activities be restricted for any reason? Please explain:

Activities may include, but are not limited to: cookouts, boating, water skiing, swimming, basketball, rollerskating, rollerblading, games in the park, soccer, broomball, ice skating, volleyball, softball, baseball, camping, downhill skiing, snowboarding, hiking, biking, concerts, Bible studies, golfing, miniature golf, hayrides. *Note: If you desire to limit your child's participation in any event, please submit your wishes in writing to the church youth pastor prior to that event.*

_____ has my permission to attend all youth activities
NAME OF STUDENT
sponsored by Vision Church (hereinafter the "Church") from _____ to _____.
DATE DATE

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.

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. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. 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 signature: _____ Date: _____