

# Medical Consent and Release for Overnight Events

(Please Print)

Activity: Pure Freedom Retreat      Dates: February 26- 27, 2010

Name of Youth \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_

Mother's (or legal guardian) Name \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's (or legal guardian) Name \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Other Emergency Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Company Covering Youth \_\_\_\_\_

Phone \_\_\_\_\_ Group or Policy Number \_\_\_\_\_

## Personal Medical Information

Known Allergies \_\_\_\_\_

Medical History \_\_\_\_\_

Current Medications \_\_\_\_\_

Dietary Restrictions \_\_\_\_\_

Physical Restrictions \_\_\_\_\_

*In the event that I am unable to be reached at the numbers above, I hereby authorize emergency medical treatment, surgery or dental care to be given to my son/daughter, listed above as considered advisable or necessary in the judgment of an emergency medical professional or attending physician I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child. I further agree to pay all charges for the dental, medical, or hospital care or treatment.*

*As parent or legal guardian of my child, I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the dental, medical, or hospital care or treatment to be rendered to my child is legally sufficient and that no consent from any other person is required by law.*

\_\_\_\_\_  
Parent (or legal guardian) Signature

\_\_\_\_\_  
Date

## Permission Agreement for Overnight Event

I give permission for my youth, \_\_\_\_\_, to participate in the planned activities of Churches Together for Kids Ministries "Pure Freedom Retreat" **dates: February 26 – 27, 2010**

I understand that reasonable plans have been made to ensure the safety and welfare of all participants. I also understand that volunteer adults will be chaperoning youth activities and will take reasonable action as they deem necessary to protect the best interests of all participants. In signing this document, my youth agrees to conduct himself in a safe and orderly Christian manner and will abide by decisions made by the adult leaders. I am aware that private transportation will be used when travel is necessary. Further, I do release and hereby agree to hold blameless Churches Together for Kids and its volunteers from any and every claim arising, or which may be asserted by me or by any member of my family by reason of Pure Freedom Retreat". I also release the lessor/owner of properties on which the Retreat is held.

I understand that the Pure Freedom Retreat will be centered around purity – body, soul, and spirit and purity, STDs (sexual transmitted diseases), relationships, boundaries, and dating will be discussed.

Further, I authorize Churches Together for Kids Ministries to use photographs and video footage of the participant for promotional materials.

I have read and understand the conditions described above, and as the parent or legal guardian of my child, I hereby consent for my child to attend and participate in all activities provided by this Churches Together for Kids Ministries "Pure Freedom Retreat".

\_\_\_\_\_  
Parent (or legal guardian) Signature

\_\_\_\_\_  
Date