SUMMERGIZE camp for kids

Medical Information Form

Event Name:_____
Event Date:_____
Circle One: Student / Adult / Child / Leader / Chaperone

Last Name:_____
First Name:_____ Middle Initial:_____

Address:_____ City:_____
State: _____ Zip Code:_____

Home Phone: (___)_____ Cell: (___)_____
Sex: M__ F__ Ht:_____ Wt:_____

Emergency Contact Information:

1st Contact Name: _____
Relationship:_____
Home Phone: (___) _____ Cell: (___)_____ Work: (___)_____

2nd Contact Name: _____
Relationship:_____
Home Phone: (___) _____ Cell: (___)_____ Work: (___)_____

Insurance Information:
___Check here if participant does not have insurance.

Insurance Company: _____ Family Physician: _____

Insurance Company Address:
_____

Subscriber Name: _____ Policy #: _____
Subscriber #: _____

Subscriber D/O/B: _____ Subscriber Phone #: (___)_____
Subscriber's Address (if different from above)_____

Medical History

**** If the participant has been exposed to a communicable disease within two weeks prior to event, please have doctors approval to participate.**

*Any operations, illness , or injuries in the last year? :_____

*Date of last Tetanus shot:_____ Date of last DPT or DT booster:_____

*Does your child have any physical or mental problems that GP Leaders should be aware of?

(For example: asthma, allergies, diabetes, depression, seizures, eating disorder, etc.)

Check One: _____NO _____YES IF YES, please explain:_____

_____

_____

*Please indicate any allergies your child has: __Bee Sting __Penicillin __Hay Fever __Poison Ivy/Oak

__Bacitracin __Sumac __Antihistamine __Other_____

*Circle the medications that GracePointe staff or volunteers may administer:

Tylenol Ibuprofen Antihistamine Tums Swimmer's Ear Epipen Other

All prescription medication must be in original container from Doctor of pharmacy and have original label including medication type, dosage, frequency, and physician's name. For safety of all participants, medication can only be administered by church staff or event leader. It is the responsibility of the parent of guardian to make these arrangements.

PLEASE ATTACH ANY ADDITIONAL MEDICAL CONCERNS

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Waiver of Liability and Medical Release

Participant's Name:_____**Event:**_____

Functions and Activities

I understand that participating in programs, recreation and other activities of GracePointe Church is a privilege. Prior to my participation in such activities, I acknowledge that there are certain risks associated with these activities, including, by way of example, physical injury due to activity-related accidents, physical injury due to transportation-related accidents, illness or even death. In addition, I acknowledge that there may be other risks inherent in these activities of which I may not be presently aware.

Release of Liability

By signing this Permission and Waiver Form, I expressly warrant that this child named above or I, if I am a participant, am capable of withstanding both the physical and mental demands of these activities. I also expressly assume all risks to the child or me participating in the activities, whether such risks are known or unknown to me at this time. I further release the church and its ministers, leaders, employees, volunteers and agents from any claim that my child may have or that I may against them as a result of injury or illness incurred during the course of participation in these activities. This release of liability is also intended to cover all claims that members of the child's or my family or estate, heirs, representatives or assigns may have against the church or its ministers, leaders, employees, volunteers, or agents. I further agree to indemnify and hold harmless the church and its ministers, leaders, employees, volunteers, or agents from any and all claims arising from my participation in its activities and programs, or as a result of injury or illness of my child during such activities.

First Aid and Emergency Medical Treatment

I recognize that there may be occasions where the child named above or I, if I am a participant, may be in need of first aid or emergency medical treatment as a result of an accident, illness, or other health condition or injury. I do hereby give permission for agents of the church to seek and secure any needed medical attention or treatment for the child named above or me, if I am a participant, including hospitalization, if in the agent's opinion such need arises. In doing so, I agree to pay all fees and costs arising from this action to obtain medical treatment. I give permission for attending physician(s) and other medical personnel to administer any needed medical treatment, including surgery and, again, I agree to pay for the medical treatment.

_____

X_____X_____

PRINT Name of Parent/Guardian (Responsible Party)**SIGNATURE** of Parent/Guardian (Responsible Party) **DATE**

Mailing Address:_____ City:_____ State:_____ Zip:_____

Phone#: (___)_____

****PLEASE DO NOT ARRIVE FOR EVENT WITHOUT PROPER NOTARIZATION*****

I,_____, a Notary Public for _____ County, _____(state), do herby certify that _____ personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

WITNESS my/our hand and seal, this the _____ Day of _____, 20_____.

X_____

SIGNATURE of NOTARY PUBLIC

My Commission expires _____, 20_____.

****NOTARY STAMP of SEAL Required****