

MEDICAL RELEASE FORM

(This PAGE to be filled out by parent/guardian of minor)

Youth Events for 2015

Mt. Olive Lutheran Church – 11500 E Iliff Ave – Aurora, CO – 80014 – 303.755.9123 – Fax 303.745.5912

NAME _____ Birth Date _____ M/F Age _____
Last First

Parent/Guardian _____

Home Address _____ Phone _____
Street Address City State Zip Area/Number

(If not available in an emergency, notify the person below)

Emergency Contact Name _____

Address _____ Phone _____
Street Address City State Zip Area/Number

Family Doctor Name _____

Address _____ Phone _____
Street Address City State Zip Area/Number

Family Medical Insurance Company Name _____

Address _____ Phone _____
Street Address City State Zip Area/Number

ID Number/Policy Number _____

PARENT PERMISSION & ENDORSEMENT

_____ (child's name) has permission to engage in all prescribed activities for this event including. I hereby assume the risk of all injuries to the person herein described & I release & discharge Mt. Olive Lutheran Church, its agents & employees, from any & all liability that results from injury to the person herein described. Insurance protection is my responsibility.

Authorization for Treatment: I give permission for the Adult Counselors and Leaders to administer medications as it deems necessary to me or my child, including medications sent with my child, or nonprescription medications available. In the case of an emergency I know every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the Adult Counselors and Leaders to hospitalize & secure proper treatment for me or my child. I assume financial responsibility for actions which may cause damage to property. If the Adult Counselors and Leaders deem it necessary for my child to be removed from this event, due to disciplinary or other problems, I will respond by promptly picking up my child.

I give my permission for my child's picture to be used in any church related publicity.

_____ Yes _____ No

Please list any allergies, dietary needs, medicines, medical conditions, or any other considerations regarding the health of your child:

Date _____ Parent/Guardian Signature _____