MEDICAL CONSENT AND LIABILITY AND ACTIVITY RELEASE FORM

Must be completed and carried by all participants. Copy must be given to group leader.
Must be signed by parent or guardian of participants under 18.
Please type or print legibly in ink.

PARTICIPANT NAME: (Last) ____________________________ (First) ___________________________

BIRTH DATE: ____/____/______ MALE:_____ FEMALE:_____

HOME ADDRESS: ____

CITY/STATE/ZIP: ____

HOME PHONE: ( ) ________________________ DAY PHONE: ( )________________________

CUSTODIAL PARENT/GUARDIAN: ____

HOME PHONE: ( ) ________________________ DAY PHONE: ( )________________________

HOME ADDRESS (IF DIFFERENT) ____

HEALTH PLAN CARRIER: ____

NAME OF INSURED: ____

RELATIONSHIP TO PARTICIPANT: ____

POLICY HOLDER OR INSURANCE ID NUMBER:____

FAMILY DOCTOR: ____

OFFICE PHONE: ( )________________________ MEDICAL EXCHANGE: ( ) _______________

FAMILY DENTIST: ___________________________ OFFICE PHONE: ( ) ____________________

SECOND PARENT OR EMERGENCY CONTACT PERSON: _________________________________

RELATIONSHIP TO PARTICIPANT: ____

HOME PHONE: ( ) ________________________ DAY PHONE: ( ) ________________________

Please specify if any health insurance pre-certification, notification, or other requirements exist for the participant:____

Medical Card Copy Front Medical Card Copy Back

CONSENT (continued)

I understand that the Mission Trip for which this Medical Consent and Liability and Activity Release Form is being given is described as follows: (DESCRIPTION OF SERVANT EVENT, INCLUDING LOCATION, DATES, SPONSOR AND ACTIVITIES, PARTICULARLY ANY HAZARDOUS ACTIVITIES.)______________________
____
I hereby consent to participation of myself (or of my child) in the above-described Mission Trip. I have read the informational materials regarding the planned activities. I am aware that in addition to activities such as Bible study, worship, sight-seeing, using public transportation, and meal functions, the participant also may be asked to participate in various servant activities that may involve additional risks, such as
____
____
I understand that I have a duty to provide primary accident and medical insurance for myself (or for my child) and I declare that I am (or my child is) covered by primary accident and medical insurance.

I RELEASE AND FOREVER DISCHARGE THE LUTHERAN CHURCH—MISSOURI SYNOD, CAMPUS LUTHERAN CHURCH, ANDTHEIR AGENTS AND SERVANTS, SUCCESSORS AND ASSIGNS, DIRECTORS, TRUSTEES, OFFICERS, EMPLOYEES, AND OTHER REPRESENTATIVES FROM ANY AND ALL DAMAGES OF MY [OR MY CHILD'S] PARTICIPATION IN, ATTENDANCE AT, AND TRAVEL TO AND FROM THE EVENT. FURTHERMORE, I DO HEREBY EXPRESSLY STIPULATE, AND AGREE TO INDEMNIFY AND HOLD FOREVER HARMLESS THE DYM, SYNOD, CAMPUS LUTHERAN CHURCH AND ITS AGENTS AND SERVANTS, SUCCESSORS AND ASSIGNS, DIRECTORS, TRUSTEES, OFFICERS, EMPLOYEES, AND OTHER REPRESENTATIVES AGAINST LOSS FROM ANY AND ALL PRESENT OR FUTURE CLAIMS, DEMANDS, OR ACTIONS IN LAW OR IN EQUITY THAT MAY HEREAFTER BE MADE OR BROUGHT BY ME OR MY CHILD, BY ANYONE ON BEHALF OF ME OR MY CHILD, OR BY ANYONE ELSE ON THEIR OWN BEHALF FOR DAMAGES OR ANY OTHER LEGAL OR EQUITABLE REMEDY ON ACCOUNT OF ANY INJURY, ILLNESS, PHYSICAL CONDITION, INCONVENIENCE, OR LOSS SUSTAINED BY ME OR MY CHILD DURING THE SERVANT EVENT OR TRAVEL TO AND FROM THE SAME.

I, the undersigned, hereby acknowledge that I have read the foregoing, understand its contents, and have signed the same as my own free act and deed.

FOR PARTICIPANTS AGE 18 AND OVER:

______________________________	______________	______________________________
Participant Signature	Date	Witness

FOR PARTICIPANTS UNDER AGE 18:

______________________________	______________	______________________________
Parent/Guardian (If participant is under 18)	Date	Witness

EMERGENCY MEDICAL INFORMATION FORM

Please complete so that health providers can be aware of your personal health needs.
Must be completed by all Event participants.

Name of Participant: ____

Does participant have: (if "yes" explain)

____Yes ____No ALLERGIES?
____Yes ____No HEART CONDITION? ______________________________
____Yes ____No OTHER?______________________________________

Is participant subject to: (If "yes" explain)

____Yes ____No HEADACHES?__________________________________
____Yes ____No SEIZURES? __________________________________
____Yes ____No MOTION SICKNESS? ____________________________
____Yes ____No FAINTING? __________________________________
____Yes ____No SLEEP WALKING? ______________________________
____Yes ____No UPSET STOMACH? ______________________________
____Yes ____No OTHER?_____________________________________

Does participant have reaction to: (If "yes" explain)

____Yes ____No BEE STING? _________________________________
____Yes ____No PENICILLIN? _________________________________
____Yes ____No OTHER DRUGS?________________________________
____Yes ____No POISON IVY, OAK, SUMAC? _______________________
____Yes ____No OTHER?_____________________________________

____Yes ____No Has the participant had any serious illness or surgery within the past ten years?
Please list: ____________________________________
____Yes ____No Does the participant have any condition that would prevent him/her from participating in any Servant Event activities?
Please list: ____________________________________
____Yes ____No Does the participant take any prescription medication?
Please list: ____________________________________
____Yes ____No Are any drugs ineffective in treatment? ____________________
____Yes ____No Is the participant diabetic? Medication? ___________________
____Yes ____No Does the participant have any sight or hearing impairment? __________
____Yes ____No Does the participant wear contact lenses? __________________
____Yes ____No Does the participant wear hearing aids? ___________________

Blood type: ______________________ Date of last tetanus shot: ____________________

A current tetanus shot is required. After 5 years, another tetanus shot is recommended.

Please indicate ANYTHING else that leaders should know to help avoid or deal with any medical situation that might arise: ____

____