Hope Church Student Ministries

Authorization for Medical Treatment

Event Name: **Chasm Retreat Nov. 2-4, 2018**

Student Information

_____ _____ _____
Student Name Gender Grade

_____ _____
Parent / guardian Name Email

_____ _____ _____ _____
Address City State Zip

_____ _____
Home phone Mobile phone

_____ _____
Medical / health insurance company Insurance policy no.

_____ _____ _____
In case of emergency, if parent/guardian can't be reached, notify phone Relationship to minor

_____
Allergies / allergic reaction of my child

_____
Medicine being taken by my child

Please list any major surgeries or medical issues that happened within the past 5 years in the space below. Please also give any other information regarding your child's health that could be important for doctors or leaders to know:

****This form should be turned into the Student Ministries Drop Box by Sunday, October 28.* ***IF your child has special needs, allergies, or conditions that would be important for the leadership to consider as they plan and prepare for the retreat, please take the time to give the student ministries staff a phone call.***

Hope Church
4934 Western Row Road
Mason, OH, 45040
513-459-0800
jtinsley@hopemason.org

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Additional Information

I, _____, am the parent or legal guardian of _____,
Name of parent or guardian — Name of minor

hereinafter, “my child”, who was born on _____, _____. My child is attending and participating in activities at _Higher Grounds Camp___ (hereinafter, "camp,” “church,” “school,” etc.), located at
Name of organization

__3820 Logan Creek Ln_ in the city of __West Harrison_____, state of ___Indiana_____,
Address

beginning on the day of ___November 2, 2018_____ and ending on November 4, 2018. I hereby authorize Hope Church and his/her officers, agents, and his/her servants, or employees who are 18 years of age or older, who supervise the activities at _Higher Grounds Camp__ into whose care my child has been entrusted,
Camp / church

to consent to medical care or dental care, or both, for my child. The authority granted by this authorization includes the authority to 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 authorize the Hope Church and his/her officers, agents, servants, or employees who are 18 years of age or older, who supervise the activities at the Higher Grounds Camp to receive physical custody of my child upon
Camp / church

completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to the Hope Church Student Ministry and his/her officers, agents, servants, or employees who are 18 years of age or older who supervise the activities at this Higher Grounds Camp
Camp / church

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his/her authorized designee, in the exercise his/her best judgment on what is advisable for my child’s care, upon advice of such physician, dentist, and surgeon. In addition, I have, and do hereby release Hope Church, its staff, employees or agents from liability associated with participation in a church activity.
I understand that if I do not have medical insurance, I, as the parent/guardian will be responsible for any medical expenses in the event of a sickness and/or injury. I understand that there are risks involved in taking place in recreation activities and/or other activities related to participation in youth functions.

Dated _____, _____ _____
Signature of parent or legal guardian

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