

MEDICAL PERMISSION AND LIABILITY RELEASE FORM
June 14 – June 18 2010 Camp Flip Flop

We (I) the parent(s) or legal guardian(s) of _____ hereby grant our (my) permission for him/her to participate fully in events and activities sponsored by Camp Flip Flop during the time period of June 14- June18, 2010.

Authorization and permission is hereby given to said church/camp to furnish any necessary transportation, food, and lodging, for this participant during the excursions and activities of the camp program.

I understand all safety precautions will be taken at all times and during all events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Camp Flip Flop, its leaders, employees, and/or volunteer staff liable for damages, losses, diseases, or injuries incurred by the participant who is the subject of this form. Furthermore, I (and on behalf of my youth - participant if under the age of 21 years) hereby assume all risk of personal injury, sickness, death, damage, and expense as a result of participation in recreation and work activities involved therein.

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached or the alternate contact person cannot be reached in an emergency I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that my insurance coverage for my child will be used as primary coverage in the event medical intervention is needed.

Further, should it be necessary for the participant to return home due to medical reasons, disciplinary action, or otherwise, I hereby assume all transportation costs.

Parent/s

Legal Guardian

Participant, if age 21

Please fill out attached Health Form.

Camp Flip Flop

(Please Print)

Name of student _____ Date of Birth _____

Address _____ Age _____

Town _____ State _____ Zip _____

Phone Number (____) _____ Sex _____ Height _____

Emergency Contact Person:

Parent/Guardian Name _____

Address (if different from student)

City _____ State _____ Zip _____

Phone Number (**Home**) (____) _____ Phone Number (**Work**) (____) _____

Phone Number (**Cell**) (____) _____ Phone Number (**Other**) (____) _____

Alternate Contact Person: (Use someone near the primary contact)

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (**Home**) (____) _____ Phone Number (**Work**) (____) _____

Phone Number (**Cell**) (____) _____ Phone Number (**Other**) (____) _____

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury incurred during any Youth Ministry function or activity.

Do you have health insurance? _____ Yes _____ No

Name of Insurance Company

Policy Number _____ Group Number _____

In whose name is the insurance? _____

Family Doctor _____ City _____

Phone Number (____) _____

If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him/her proper medical care during his/her time with the youth ministry activity.

Health History:

Pre-existing or present medical conditions _____

Name and dosage of any medications that must be taken

Any allergies? _____ to medications? _____

Hay Fever Heart Condition Diabetes Insect Stings

Epilepsy/Nervous Disorders Asthma Frequent Stomach Upsets

Physical Handicap Any major illnesses during the past year?

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions)

Date of Last Tetanus Shot _____ Contact Lenses? _____

Any swimming restrictions? Yes No

What? _____

Any activity restrictions? Yes No

What? _____