



SUGARLOAF UNITED METHODIST CHURCH STUDENT LIFE HEALTH, CONSENT AND RELEASE FORM

Note To Parent/Guardian: Student Life wants all of our camps, missions trips, retreats, and events to be safe and healthy ones. However, in the event of an accident or illness, it is important that we have the following information.

Name of Student _____ Birth-date of Student _____ Sex _____
 School _____ Grade _____
 Home Address _____ City _____ State ____ Zip _____
 Home Phone _____ Student Cell Phone _____
 Father's Name _____ Email _____
 Father's Work Phone _____ Father's Cell Phone _____
 Mother's Name _____ Email _____
 Mother's Work Phone _____ Mother's Cell Phone _____
 Second Parent or Guardian Emergency Contact Name (and relationship) _____
 Home Phone _____ Business Phone _____ Cell Phone _____
 If not available in an emergency, notify: Name & Relationship to Student: _____
 Home Phone _____ Cell Phone _____

ACCIDENT COVERAGE

Health Insurance Company Name _____
 Group Name _____ Policy # _____
 Insurance company address _____
 Primary Physician Name _____ Phone Number _____
 Medical History _____

 Allergies _____
 Current Medications _____
 Dietary Restrictions _____
 Last Tetanus Immunization _____
 Additional Health Information / Activities to be Limited _____

AUTHORIZATION FOR TREATMENT / ACKNOWLEDGEMENT OF INHERENT RISK

This information is correct as far as I know, and the person herein described has permission to engage in all Student Life related activities except as noted.

I hereby give permission to the medical personnel selected by the Student Life staff of Sugarloaf United Methodist Church to order X-rays, routine tests, treatment; to maintain and/or release any medical records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In an emergency, I hereby give permission and authorize the physician selected by Student Life to secure or administer emergency medical treatment, including hospitalization and any other emergency medical procedures which may be needed for the person named above. I authorize the physician or dentist to call in any necessary consultants in his/her discretion. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise their best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment. I agree to remain fully liable and responsible for the payment of any such hospital, doctor, ambulance, dental or medical fees. I further agree that in giving this permission and authorization, Student Life and Sugarloaf United Methodist Church do not assume any responsibility or liability for the payment of such hospital, doctor, ambulance, dental or other medical fees which may be incurred. The completed forms may be photocopied and maintained by authorized personnel. This form, both front and back, is valid by my permission through December 31, 2010.

Signature of parent or guardian _____ **Date** _____

Turn over

RELEASE OF LIABILITY

I acknowledge and understand there are inherent risks associated with many Student Life activities. I will assume the risk associated therewith, whether known or unknown to me at this time. I recognize that my student's attendance at a Sugarloaf United Methodist Church sponsored event is a privilege and as a consideration for this privilege, I release Sugarloaf United Methodist Church, including its employees, agents and trustees, from responsibility for my student's accidental physical injury, including death or illness while at a sponsored trip or activity or during travel to and from events. This release is intended to include all claims made by my family, estate, heirs, personal representatives or assigns.

Signature of Parent / Guardian _____ **Date** _____

MEDIA CONSENT

I hereby grant permission to Student Life and Sugarloaf United Methodist Church the right to take, use, reproduce, and/or distribute photographs, films, video, and sound recordings of my child, without compensation or approval rights, for use in materials created for purposes of promoting the activities of Student Life.

Signature of Parent _____ **Date** _____

DEPOSITS AS BINDING

I understand that all deposits made for Student Life sponsored events are non-refundable and may or may not be refunded at the discretion of Student Life staff. I also understand and acknowledge that by paying a deposit I am making a reservation and committing to paying the total cost of the trip or event. In the event I must cancel that reservation, or if my student does not live up to the required expectations laid forth for that trip, I will pay the remaining balance if Student Life is unable to recoup that loss.

Signature of Parent _____ **Date** _____

PARENT COVENANT

Student Life leadership reserves the right to send any student home, at your personal expense, in the event that a serious behavioral incident does occur with your son or daughter on any trip or activity. The leadership team will assess the situation, make a decision, call the parent and give options to what action will then take place. Examples may include, but are not limited to, fighting, drug or alcohol use, sexual activity, vandalism, violent behavior, and disobedient behavior.

Signature of Parent _____ **Date** _____

MINOR MEDICAL CARE

During Student Life sponsored trips or activities, it's always inevitable that students have minor health and first aid issues. I hereby give permission for Student Life and it's agents to administer the following over-the-counter medication and/or first aid to my child (please check all that apply).

- | | | |
|--|---|---|
| <input type="checkbox"/> Advil (Ibuprofen) | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Dramamine |
| <input type="checkbox"/> Cough Medicine | <input type="checkbox"/> Tums | <input type="checkbox"/> Claritin (allergy) |
| <input type="checkbox"/> Pepto Bismol | <input type="checkbox"/> Cough Drops | <input type="checkbox"/> Immodium AD (diarrhea) |
| <input type="checkbox"/> Cold Medicine | <input type="checkbox"/> Benadryl (allergy) | <input type="checkbox"/> Caladryl (itching) |
| <input type="checkbox"/> Sunscreen | <input type="checkbox"/> First Aid | <input type="checkbox"/> Anti-Itch Cream |

Parent signature _____ **Date** _____

