**Youth Mission Week**

Trinity Reformed Church of the United Church of Christ

60 N. Hanover St., Pottstown, PA 19464

July 24, 2014 7 pm through July 29, 2014 4 pm

Name of Youth Participant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Yes, my child has a current medical release form on file in the church office.

**Parent/Guardian Authorizations:** This health history on file is correct and complete as far as I know, and the person herein described has permission to engage in all activities except as noted.

I hereby give permission to the *Youth Mission Week* Leader, Rev. Lisa Martin or her designee, to seek routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I request and authorize hospitals and/or other emergency treatment facilities to have access to the information contained in this form in order to provide all necessary medical care for my child while he/she is in attendance at the *Youth Mission Week*. I give permission to *Youth Mission Week* Leader or her designee to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the *Youth Mission Week* Leader or his/her designee to secure and administer treatment, including hospitalization, for the person named above. I also agree to assume any financial responsibility for my child’s care. I agree to the release of any records necessary for insurance purposes. And, under the new HIPPA code, I give permission to release information to *Youth Mission Week* Leader/designee regarding diagnosis, treatment and necessary prescriptions. I acknowledge that no representations, warranties or guarantees as to results or cures will be made. I also understand that there are inherent risks to my child by participating in this event, even with the best of circumstances. With such knowledge I hereby accept such risks, and having read all of the above information, I hereby give permission for my son/daughter to attend this work camp.

I understand that private cars may be used for transportation and I give permission for my son/daughter to be transported by an adult driven vehicle.

I will not hold the sponsoring organizations or any individual participating in making this activity possible, responsible for any mishap in this project.

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent or Guardian)

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trinity Reformed United Church of Christ

60 N. Hanover St. Pottstown, PA 19464

610-326-2243 www.trinityuccpottstown.org

Medical/Assumption of Risks and Permission Slip

Name of Youth Participant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has this person had any medical problems of which an emergency physician would need to be aware (i.e. but not limited to: asthma, allergy to drugs, food or other, bee stings, chronic illness, headaches, heart ailment, epilepsy, diabetes, physical handicaps, emotional problems, or dietary restrictions)?

YES NO

**If “Yes” please list** **all conditions/allergies** (food, medication, bee stings, other) and describe:

Should there be any limits on physical activity? YES NO

At the present time, is this person under a physician’s care YES NO

If “Yes” please describe:

List dosage and medications you are sending with your child along with why they are taken and any possible side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of last Tetanus Booster \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any over-the-counter medications that you **DO NOT** want administered to your child?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is this person covered by medical insurance? YES NO

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to participant: \_\_\_\_\_\_\_\_\_\_\_

Is pre-authorization required by your insurance company for emergency services?

YES NO

If so, what is the phone number of the insurance company? ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of emergency contact person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ATTACH COPIES OF THE FRONT AND BACK OF YOUR CHILD’S INSURANCE CARDS TO THIS FORM.**

***If this person is below the age of legal consent, (18 years) the law requires that we have your permission to give medical service should the need arise. Please read carefully and sign below.***

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all activities except as noted. I hereby give permission to the staff or volunteers of *Trinity Reformed UCC* or his/her designee, to seek routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I request and authorize hospitals and/or other emergency treatment facilities to have access to the information contained in this form in order to provide all necessary medical care for my child while he/she is in attendance at any church activity. I give permission to *church leaders* or his/her designee to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the *church leaders* or his/her designee to secure and administer treatment, including hospitalization, for the person named above. I also agree to assume any financial responsibility for my child’s care. I agree to the release of any records necessary for insurance purposes. And, under the new HIPPA code, I give permission to release information to *church leaders*/designee regarding diagnosis, treatment and necessary prescriptions. I acknowledge that no representations, warranties or guarantees as to results or cures will be made. I also understand that there are inherent risks to my child by participating in this event, even with the best of circumstances. With such knowledge I hereby accept such risks, and having read all of the above information, I hereby give permission for my son/daughter to attend church activities.

I understand that private cars may be used for transportation and I give permission for my son/daughter to be transported by an adult driven vehicle.

I will not hold the sponsoring organizations or any individual participating in making this activity possible, responsible for any mishap in this project.

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent or Guardian)

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*

\* This form will be kept on file until December 31 of the current year and is good for all church activities. After that date, a new form must be filled out. If Insurance or other information changes, please let us know.

**Photo Release Form**

***Trinity Reformed United Church of Christ,***

***60 N. Hanover St., Pottstown, PA 19464***

**Permission to Use Photograph**

Subject: Activities or Special Events associated with Trinity Reformed United Church of Christ, Pottstown, PA 19464, taking place on or off Trinity United Church of Christ property.

I grant to Trinity Reformed United Church of Christ Leaders the right to take photographs of my child in connection with church sponsored activities, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I grant that this permission extends to other churches that join with Trinity Reformed United Church of Christ for activities or special events, including but not limited to Zion’s United Church of Christ, Pottstown, and St. Paul’s United Church of Christ, Pottstown.

I agree that the above named churches may use such photographs of my child with or without identification for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Child’s printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian’s printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian (if child is under age 18)

\* This form is valid until December 31 in the year it is signed. After that date, a new form will be requested.