ALL PARTICIPANTS SHOULD FILL OUT ALL FOUR LIABILITY AND MEDICAL RELEASE FORMS.

Each Mt. Olive Lutheran Church, Anoka, MN youth participant must complete all spaces on the Medical Consent and Liability Release Form, on the Authorization to Consent to Medical and Dental Care Form, and the Emergency Medical Information Form.

A PARENT OR GUARDIAN OF EACH PARTICIPANT UNDER 21 YEARS OLD MUST SIGN BOTH OF THE FORMS. These forms must be returned in order for the participant to attend the activities.

PARTICIPANT NAME:____

BIRTH DATE:______________________ MALE___FEMALE___

HOME ADDRESS:____

CITY/STATE/ZIP:____

HOME PHONE: (____)___________________________ DAY PHONE:_________________________________

CUSTODIAL PARENT/GUARDIAN:____

HOME PHONE: (____)____________________________DAY PHONE:__________________________________

HOME ADDRESS (IF DIFFERENT):____

BUSINESS ADDRESS:____

HEALTH PLAN CARRIER:____

CARRIER ADDRESS:____

NAME OF INSURED:____

RELATIONSHIP TO PARTICIPANT:____

SOCIAL SECURITY NUMBER OR
POLICY HOLDER OR INSURANCE ID NUMBER:____

FAMILY DOCTOR:____

OFFICE PHONE: (_____)___________________________ MEDICAL EXCHANGE: (____)___________________

FAMILY DENTIST:____ OFFICE PHONE: (_____)_______________

SECOND PARENT OR
EMERGENCY CONTACT:____
(If a relative, identify relationship)

DAY PHONE:____

Do any pre-certification, notification, or other requirements exist with respect to the health insurance of participant? If so, please specify:

I give my permission for my child's picture to be used in any church publicity. _____yes ____no

I understand that the Mt. Olive Youth Activities for which this Medical Consent and Liability Release Form being given is described as follows:

Any activity that includes servant events, smaller groups, retreats and sport activities.

I hereby consent to participation of me, or my child in the above-described events. I have understood the risks involved in the planned activities. I am aware that in addition activities such as Bible Study, worship, sight-seeing, using public transportation, and meal functions, the participant also my be asked to participate in various other activities that may involve risk, such as service projects, in addition to recreational activities.

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 discharge, **Mt. Olive Lutheran Church**, directors, trustees, officers, employees, and other representatives from any and all damages and causes of action either at law or in equity that I may have as result 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 indemnity and hold forever harmless **Mt. Olive Lutheran Church - Missouri Synod**, 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 by made or brought by me or my child, by anyone on behalf of me or remedy on account of any injury, illness, physical condition, inconvenience or loss sustained by me or my child during the 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 21 AND OVER (adult leaders, etc.):

____ ______________________________________

Participant Signature Date Witness

FOR PARTICIPANT UNDER AGE 21:

____ ______________________________________

Parent/Guardian of Participant Date Witness
If Particpant is under 21

AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE

For Participants Under 21 years old:
(I) (We), the undersigned parent(s) and/or natural guardian(s)
of____
SS#___________________________), a minor, do hereby authorize my child's Adult Leader (and/or any other adult appointed or designated by him/her) to (1)consent to medical, surgical and dental care for such minor child, (2)consent to any diagnostic tests, medical, surgical or dental procedure or treatment as may be considered therapeutically necessary by the physician, surgeon, dentist or other health care personnel providing care for such minor child, and (3)on (my) (our) behalf, to (a)employ physicians, surgeons, dentists, nurses, and other health care personnel as may be deemed necessary for such minor child, (b) admit such minor child to any hospital, clinic, emergency room, laboratory or other health care or diagnostic facility for examination, treatment, surgery or care and (c) sign all necessary consents and authorizations. It is understood that this authorization is given in advance of the occurrence of any condition or situation which would necessitate any such medical, surgical or dental care being required but is given to provide authority to obtain such care if it should be required. I fully understand the consequences of the foregoing statements and sign this AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE knowingly, freely and willingly. (Your signature must appear below or your child will not be permitted to participate.)

Parent/Guardian:_______________________________________ Date:________________________

Parent/Guardian:____ Date:________________________

I have looked at the Medical release forms and agree that the information is correct:

6th grade ________________________________ Date:__________________________
Parent/Guardian

7th grade ________________________________ Date:__________________________
Parent/Guardian

8th grade ________________________________ Date:__________________________
Parent/Guardian

9th grade ________________________________ Date:__________________________
Parent/Guardian

10th grade ________________________________ Date:__________________________
Parent/Guardian

11th grade ________________________________ Date:__________________________
Parent/Guardian

12th grade ________________________________ Date:________________________
Parent/Guardian

EMERGENCY MEDICAL INFORMATION FORM

NAME OF PARTICIPANT____

EMERGENCY AND HEALTH INFORMATION (To be completed by all participants)

General: 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 FAINTING?____
______Yes_______No SLEEP WALKING?____
______Yes_______No MOTION SICKNESS?____
______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 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?

Date of last tetanus shot:

A CURRENT TETANUS SHOT IS REQUIRED. After five 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:____

____

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