



New Life Lutheran Church

4380 Wakonda Dr
Norwalk, IA

YOUTH MEDICAL RELEASE AND CONSENT FORM (Each participant must complete this double-sided form)

NAME: _____ DATE OF BIRTH: __/__/__

ADDRESS: _____

CITY: _____ ZIP: _____ PHONE: (____)(____)(____)

NAME OF PARENT(S)/GUARDIAN(S) _____

NAME OF PHYSICIAN: _____ PHONE: (____)(____)(____)

NAME OF DENTIST: _____ PHONE: (____)(____)(____)

INSURANCE PROVIDER: _____

POLICY NUMBER: _____ PHONE: (____)(____)(____)

(Please provide a photocopy of current insurance cards)

List all current medications (prescription and non-prescription) include name and dosage:

HEALTH HISTORY: (MAJOR ILLNESSES, ALLERGIES, ETC)

_____ Date of Last Tetanus Shot __/__/__

FATHER'S EMPLOYER _____ PHONE: (____)(____)(____)

MOTHER'S EMPLOYER _____ PHONE: (____)(____)(____)

EMERGENCY CONTACT INFORMATION

NAME: _____ PHONE: PHONE: (____)(____)(____)

ADDRESS: _____ CITY: _____ ZIP _____

RELATIONSHIP TO PARTICIPANT: _____

Permission Slip, Liability Release, Expecting Respect, and Insurance Info

In the event of illness or accidental injury, this form will be presented to the attending physician if your child needs medical treatment in your absence. This will prevent delay of treatment with your signature and photocopied insurance card.

I hereby give permission for my child to participate in all activities related to New Life Lutheran Church’s Sunday School and Vacation Bible School. I understand that all activities will be conducted on church property. In return for the benefits of my child’s participation in these church activities I agree to accept responsibility for the actions of my child and assume all risk of injury to my child should such occur during these church activities.

Parent/Guardian (name) _____ "I hereby authorize the treatment, administration of anesthesia and surgical treatment for my child (name) _____ in the event of a medical emergency occurring during my absence or when hospital or medical personnel cannot contact me. This authorization extends to all medical facilities and personnel regardless of setting, in or out of a medical facility, in the treatment of my minor child."

I hereby authorize the church employee or adult chaperone to obtain medical treatment for my child as deemed necessary, after making every reasonable effort to notify me. If the church employee or chaperone is unable to contact me for any reason, he or she is further authorized to use his or her judgment in making care decisions for our child, and I agree to pay in full and be responsible for, any and all expenses incurred for this treatment.

I understand the zero tolerance policy with regard to acts of violence, illegal weapons, and illegal drug and alcohol use and agree to pick-up my child if deemed necessary for any reason by the VBS and SS leaders and/or Children’s Ministry Coordinator.

I agree that my child's image, both in print and electronically, may be used by New Life Lutheran Church for illustrative or promotional purposes. I have read and understand this document and release of liability. I agree to the terms and conditions and certify that the information provided is complete and accurate.

I will instill values of respect with my child to help him/her choose to respect all people, including themselves, and choose to treat others as we would like to be treated. My child will need to listen to the VBS and Sunday School leaders and volunteers in order to fully participate.

Together we will strive to live out Mark 12: 29-31 *“Jesus answered, “The first is, ‘Hear, O Israel: the Lord our God, the Lord is one; you shall love the Lord your God with all your heart, and with all your soul, and with all your mind, and with all your strength.’ The second is this, ‘You shall love your neighbor as yourself.’ There is no other commandment greater than these.”*

SIGNATURE OF STUDENT _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____