Liability Release/Permission Slip

PLEASE RETURN THIS FORM TO:

Life Church

901 Co Hwy 116

Fergus Falls, MN 56537

Church Office: 218-739-3886

Office Hours: 9:00AM – 4:00PM M-Th, 9:00AM – 12:00PM Fri.

**This form must be turned in before departure time.**

# Youth/Child Name:

Guardian Contact Number during event: (if different than home)

I give permission for the above named youth/child to attend/travel to Faith Haven Camp.

### LIABILITY RELEASE

I understand my child:

1. will be transported in Buses rented from Ottertail Minn-Dakota Coaches
2. will participate in Summer Camp
3. you can contact Pastor Mason at (308)-293-3064;
4. will return at/to Life Church.

We (I) do hereby release, absolve, and agree to hold harmless Life Church and the directors (employees and/or volunteers) thereof from any and all liability, claims, or demands for personal injury, sickness or death, as well as property damages, and expenses, of any nature whatsoever which may be incurred by the undersigned and the youth participant that occur while said youth is participating in the above described trip or activity.

Furthermore, we (I) hereby assume all risk of personal injury, sickness, death, damage, and expense as a result of participation in the recreation and work activities involved therein. Further, authorization and permission is hereby given to Life Church and its directors to furnish any necessary transportation, food, and lodging for this participant.

The undersigned further hereby agree to hold harmless, defend, and indemnify Life Church, its directors, employees and agents, for any liability sustained as a result of negligent, willful, or intentional acts of said participant, including expenses incurred attendant thereto.

We (I) hereby grant permission for the above mentioned to participate fully in said trip or activity, and hereby give permission to take said participant to a doctor or hospital and hereby authorize medical treatment, including but not in limitation to emergency surgery or medical treatment, and assume the responsibility of all medical bills, if any.

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

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

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

**Activities Release**

Students will participate in swimming, sports, and other physical activities at this camp.

Please inform us of any limitations your student may have concerning physical activity that we should be aware of. (We will do our best to accommodate for their needs)

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I give permission for my child to participate in activities at camp – in recognition of the above signed liability release, as well as and accommodating for the above listed limitations (if any).

**Parent Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Release and Instructions for Youth Student**

**Effective dates : July 25th- July 30th**

**Please print in ink**

**The medication noted on this form is intended for use by:**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

 Male  Female Age \_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Parent Cell Phone

**Medication name is:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Detailed dosage instructions – specify amount and time:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Self-administered** **Camp Nurse Administered**

**Medication name is:**

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**\*Detailed dosage instructions – specify amount and time:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Self-administered** **Camp Nurse Administered**

Additional comments:

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**\*All prescription medication must be in its original container and be clearly labeled with dosing instructions.**

1. Place medication in a clear zip-type bag
2. Label bag with youth’s name
3. Attach this form to the outside of the bag

I give permission for my child to receive/take medication as indicated in dosage instructions as written above.

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

In case of a medical emergency where a student needs to be taken to a local hospital and to ensure that your student be able to receive care if we were unable to get in contact with you (parent/guardian), we request that you provide us your insurance provider and policy number.

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Emergency Contact Information:**

In case of a medical emergency, please provide emergency contact information for multiple parent/guardians (if possible) as well as an alternative emergency contact if neither guardian is able to be reached (e.g., a grandparent, aunt/uncle, close family friend).

\*Note: Under the above signed Liability Release, you have authorized Life Church to take your student to a doctor or hospital to receive medical treatment if deemed necessary

Parent/Guardian 1

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian 2

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternative Emergency Contact

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Over The Counter Medication Release**

My student has permission to receive over the counter medications as needed while at camp, dispensed according to package directions by the camp nurse or director, such as:

Tylenol, Advil, Ibuprofen, Nausea, Allergy, or other applicable medication or basic first aid.

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Known Allergies, Medical Conditions To Be Aware Of**

Please indicate below any allergies your student has.

**Allergies to Medications:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Food Allergies:**

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**Known Medical Conditions:**

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**Other Notes:**

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