



## Permission Form & Medical/Liability Release

Name of Participant: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ has my permission to attend all activities sponsored by Great Plains Church on **July 24-25, 2015** at (or near) **El Dorado Lake, KS.**

Activities may include, but are not limited to: overnight camping, campfires, cooking over fire, swimming, boating, running, hiking, and being outside in summer sun/heat.

Note: If you desire to limit your child's participation in any event, please submit your wishes in writing to the church prior to that event.

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases Great Plains Church and its staff or volunteers sponsoring the event of any liability against personal losses of named child.

I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by Great Plains Church. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release Great Plains Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by Great Plains Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by a staff member or person(s) in charge.

Medical Insurance Company Name: \_\_\_\_\_

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

Primary Care Physician: \_\_\_\_\_

For your child's safety and our knowledge, please complete the following short medical history.

Does your child suffer from:  asthma  epilepsy  heart trouble  diabetes  
 frequent upset stomach  physical handicap  other: \_\_\_\_\_

Is your child allergic to:  medications  food  other: \_\_\_\_\_

Please list any medications and dosages that will need to be dispensed, as well as when to be given:

\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Parent/Guardian Phone Number

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Date