

# "2-Page" Parental Consent and Release of Liability

Hope Lutheran Church / 364 E Barstow Ave. / Fresno, CA 93710 / 559 439 4320

**Intended to Cover - Youth Events from September 1, 2009 – August 31, 2010**

Individual's Name (herein "Student") \_\_\_\_\_

Parent(s) Name (herein "Parent/Guardian") \_\_\_\_\_

Hope Lutheran Church (herein "Organization") Adam D. Knudson (herein "Agent")

## STUDENT INFORMATION

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

Phone: (hm) \_\_\_\_\_ (wk) \_\_\_\_\_ (cell) \_\_\_\_\_

Neighbor/Relative (if unable to reach parent at above phone) and state relationship: \_\_\_\_\_

Address & Phone: \_\_\_\_\_

Student's Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Name of Insurance Co. : \_\_\_\_\_ Insurance Co. Phone #: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Date Policy Expires: \_\_\_\_\_

Claim Office Address: \_\_\_\_\_

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

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

Student's Birthdate: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_ Confirmation of HepA & HepB Vaccinations: \_\_\_\_\_

Allergies: Food: \_\_\_\_\_ Hay Fever: \_\_\_\_\_

Insects: \_\_\_\_\_ Other Allergies: \_\_\_\_\_

How are allergic reactions handled at home?: \_\_\_\_\_

Medications: \_\_\_\_\_

Use of Meds: \_\_\_\_\_

Activity Restrictions or Special Medical Conditions: \_\_\_\_\_

Other Medical Info We Might need to Know: \_\_\_\_\_

# PERMISSION & RELEASE OF LIABILITY

WHEREAS, I (Parent/Guardian) \_\_\_\_\_, give my permission for my child named above to participate in educational, recreational, and service related trips and related activities sponsored by Hope Lutheran Church (Fresno, California), and

WHEREAS, I recognize that the participation in such activities may be hazardous and dangerous.

NOW THEREFORE, I do hereby, for myself, my heirs, executor and/or administrator, remise, release and forever discharge Hope Lutheran Church and all its officers, agents, servants and employees, acting officially or otherwise, from any and all actions, causes of action, claims and demands from, upon, or by reason of any injury, damage, loss or death which may occur from any cause including, but not limited to, any accident while participating individually or with others in said events.

\_\_\_\_\_  
signature of Mother/Guardian

\_\_\_\_\_  
date

\_\_\_\_\_  
signature of Father/Guardian

\_\_\_\_\_  
date

## CONSENT TO TREATMENT

(To be Completed if child is under 18 years of Age)

I (Parent/Guardian) \_\_\_\_\_, authorize the youth leader(s) of Hope Lutheran Church to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care or service which is deemed advisable and is rendered under the general or specific supervision of any licensed physician and surgeon, or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being rendered, but is given to provide authority and power on the part of the Agent to give specific consent to any and all such diagnosis, treatment, or hospital care which the above mentioned physician, in the exercise of his/her best judgment, may deem advisable. I authorize the group leader(s) of Hope Lutheran Church to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care or service which is deemed advisable and is rendered under the general or specific supervision of any licensed physician and surgeon, or the medical staff of a licensed hospital.

I authorize any hospital which has provided treatment to my child to surrender physical custody of my child to the group leaders upon completion of treatment.

These authorizations shall remain effective through the above periods unless sooner revoked in writing and delivered to the Agent.

\_\_\_\_\_  
signature of Mother/Guardian

\_\_\_\_\_  
date

\_\_\_\_\_  
signature of Father/Guardian

\_\_\_\_\_  
date