REACH 2019

STUDENT MEDICAL AUTHORIZATION FORM

Church attending with:____

Group leader:________________________ Phone:________________________

Participant:________________________ Phone:________________________

Address (street/city/state/zip):________________________________

Birthdate:__/__/__ Age:___ Gender: ______ Grade completed:________________

Parent/Guardian:______________________ Phone: ________________________

In case of medical emergency, contact:

Name: ________________________ Phone:________________________

Medical insurance

Insurance Name:____________________ Policy # ________________________

Current Medications:____________________ ↑DO NOT Leave Policy # Blank!!↑

Allergies or Current Medical Conditions:________________________________

<u>If you do not have Medical Insurance YOU MUST FILL OUT THE INSURANCE WAIVER ON BACK</u>

[ ] I DO NOT HAVE MEDICAL INSURANCE AND HAVE FILLED OUT THE BACK

As parent/legal guardian of the above named participant, I give permission for my child to be involved in REACH on February 15-18, 2019 with The Alliance Northwest District of the Christian and Missionary Alliance. I understand that the church (listed above) and its appointed group leader (named above) will be responsible for my child and that he/she will be under their supervision.

I understand that in the event of a medical emergency, an earnest attempt will be made to contact me or the emergency contact listed above. In the event that I cannot be reached, I hereby give permission to the physician to hospitalize, secure treatment for, and order injection, anesthesia or surgery if circumstances warrant such action.

As parent/legal guardian of the above named participant, I assume the risk for my child's behavior or conduct outside of the standards of the conference and Christian character. I also hold The Alliance Northwest District of the Christian and Missionary Alliance, its agents, employees and representatives harmless from any liability to any other person or entity arising as a result of the conduct of my child in this conference and agree to defend and indemnify you, your agents, employees and representatives against any claim or liability arising as a result of such conduct.

Parent/Guardian Name (PRINT):________________________

Parent/Guardian Signature:________________________ Date:____/____/____

Group Leader: It is your responsibility to ensure that this form is filled out completely. Any student that arrives with an incomplete form will not be allowed to stay (<u>this includes missing signatures and policy numbers</u>). Do NOT MAIL THIS FORM to the Alliance NW. Bring all Medical Authorization Forms with you to REACH in the unlikely event of an emergency.

Medical Insurance Absence Waiver

Only to be filled out should you NOT have medical insurance

I understand that The Alliance Northwest District of the Christian and Missionary Alliance liability insurance does not cover medical issues that are not directly caused by negligence. This can include injury or sickness caused by a person due to horseplay, self inflicted accidents, common sickness and the like. This may include but is not limited to colds, stomach cramps, fainting, seizures, broken teeth, trips and falls causing the need for stitches or even broken bones.

I understand that hospitals will see my child without insurance only for life-threatening issues. If my child is sick or hurt in a non life-threatening way, I am committed, willing and available to personally drive and pick up my child and personally take them to seek medical attention. I understand that even minor issues may cause me to come pick up my child so that the responsibility of the health of my child remains on me and not on The Alliance Northwest District of the Christian and Missionary Alliance.

Parent/Guardian Signature:____

Parent/Guardian Name (PRINT):____

Date:_____/_______/______

Phone: ___________________________Cell:_________________________

If not available at this number please call:

Name:___________________________Phone:_______________________

Group Leader: It is your responsibility to ensure that this form is filled out completely. Any student/leader that arrives with an incomplete form will not be allowed to stay (this includes missing signatures and policy numbers). Do NOT MAIL THIS FORM to the Alliance NW. Bring all Medical Authorization Forms with you to REACH in the unlikely event of an emergency.

GUEST CONSENT RELEASE FORM FOR OUTSIDE GROUPS USING YOUNG LIFE CAMP

NOTE TO GUEST: Young Life wants your experience at the Young Life camps to be a safe and healthy one. However, in the event of an accident or illness, it is important that we have the following information.

Name____
Last First Middle Initial

Birthdate______________ **Age**______ **Sex**________

Spouse/First Emergency Contact______________________________
Last First Middle Initial

Home Address____
Street and Number City State/Province Zip/Postal

Business Address______________________________________
Street and Number City State/Province Zip/Postal

Phone Number **Home**____________________ **Business**____________________

Second Emergency Contact__________________________________
Last First Middle Initial

Home Address____
Street and Number City State/Province Zip/Postal

Business Address______________________________________
Street and Number City State/Province Zip/Postal

Phone Number **Home**____________________ **Business**____________________

Any allergies or other medical needs? ______________________________

Name of Physician______________________________ ______________
Last First Middle Initial Phone Number

Address____
Street and Number City State/Province Zip/Postal

☐ I have had a physical within the last 24 months.

Medical Insurance Company__________________________ **Policy Number**______________

Address____
Street and Number City State/Province Zip/Postal

INDEMNITY AND CONTRACT AGREEMENT:
I will not hold or attempt to hold Young Life liable for any loss, damage or injury to person or property caused by any act or neglect of other persons on or about the Property, or caused in any manner other than the willful or negligent act of Young Life, its agents and employees, and will indemnify and hold Young Life harmless from any liability for damages or claims against Young Life arising out of or in any way related to any such loss, damage or injury.

I release Young Life, including its trustees, employees and agents, from my physical injury, including death, or illness while at the Property. I will assume the risk associated therewith, whether known or unknown to me at this time. This release is also intended to include all claims of my family, estate, heirs, personal representatives or assigns.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to secure and administer treatment and to maintain and/or release any medical records necessary for insurance purposes as outlined under the HIPAA regulation, and to provide or arrange necessary related transportation for the above named person. To obtain a copy of Young Life's Notice of Privacy Practices, log on to www.younglife.org or call (719) 381-1950).
I verify that I am in good health and am capable of participating in strenuous activities, and when necessary, will tailor my activities to those within the bounds of my physical health. In Colorado, campers will participate in rigorous activities at 9,000 to 14,000 feet. I recognize that any medical treatment that is provided to me while attending a Young Life camp will be paid for by my medical insurance company.

WAIVER AND RELEASE
IF I AM UNDER AGE 18, MY PARENT OR GUARDIAN, BY SIGNING BELOW, ALSO CONSENTS TO MY RELEASE AND HE OR SHE AGREES THAT THIS RELEASE SHALL BE BINDING UPON HIM OR HER AS MY PARENT OR GUARDIAN AS TO ME AND MY ESTATE, HEIRS, PERSONAL REPRESENTATIVES AND ASSIGNS. MY PARENT OR GUARDIAN ALSO PROMISES, BY SIGNING BELOW TO DEFEND, INDEMNIFY AND HOLD YOUNG LIFE HARMLESS FROM ANY CLAIM ASSERTED BY ME AGAINST YOUNG LIFE, INCLUDING ITS TRUSTEES, EMPLOYEES AND AGENTS, IF I SHOULD REPUDIATE THIS RELEASE AFTER OBTAINING ADULTHOOD.

Signature__________________________ Date____________

Name of Your Group/Church________________________ Dates of Event____________

YL-6009 (April 09) Printed in U.S.A

Medical Release/Consent Form

Mercer Creek Church

Event Name: REACH: Washington Family Ranch in Antelope, OR____________

Dates: _February 15-18, 2019____

Student's name: ____ D.O.B.__________

Address: ____ Phone: ____________

_____________________ Parent Email: ____________________________

Parents'/Guardians' Names: ____________________________ Phone: __________

Address (if different from child's): ____

____

Insurance Co.: _____________________________ Policy #: ________________

Person to contact if parent /guardian cannot be reached: _____________________

Relationship: __________________________ Phone: _________________________

Allergies?: ____ Bee sting ____ Pollens ____ other_______________________

____Hay, straw ____Penicillin ____other drugs___________________

_____ Major illnesses during the past year? ____ Frequent Stomach Upsets

If any of the above are checked, please give details to include normal treatment of allergic reactions.

____

Any life-threatening allergies? ____ Yes ___No If yes, to what?

____

Bringing any medications ____ Yes ____No If yes, please list and state dosage:

____

Please note: Medication should be in its original prescription bottle/package, which should have administration instructions and the individual's name clearly indicated.

Any physical, emotional, mental or behavioral concerns or limitations that our staff should be aware of? ____Yes ____ No If yes, please explain:

____

Any swimming restrictions? ____ Yes ____ No Contact Lenses? ____ Yes ____No

Date of last tetanus shot: ______________________

--Over--

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during the activity dates shown on this form, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and /or to order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that my insurance coverage will be used as primary coverage in the event medical intervention is needed. Coverage by Mercer Creek Church through its accident policy will be used as a backup for what my family's insurance does not cover.

I understand all reasonable safety precautions will be taken at all times by Mercer Creek Church and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Mercer Creek Church, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

Signature of Student: ______________________________

Printed Name: ______________________________ Date: ____________________

Parent/Guardian Signature (If Student is under 18): ______________________________

Printed Name: ______________________________ Date: ____________________