Christ Church, Presbyterian, Evans, Georgia
Emergency Medical Release

PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS WILL BE RETURNED. PLEASE TYPE OR PRINT.

Participant's Name _____ Birth Date _____

Street Address _____

City _____ State _____ Zip _____

EMERGENCY INFORMATION

Father's Name_____ Home Phone (_____) _____ Bus Phone (_____) _____
Cell Phone (_____) _____

Mother's Name_____ Home Phone (_____) _____ Bus Phone (_____)_____
Cell Phone (_____) _____

In an emergency when parent / guardian cannot be reached, please contact the following:

*Name*_____ *Home Phone (_____)* _____ *Bus Phone (_____)* _____
Cell Phone (_____) _____

*Name*_____ *Home Phone (_____)* _____ *Bus Phone (_____)* _____
Cell Phone (_____) _____

Allergies_____

Other Medical Conditions_____

Physician_____ Home Phone (_____)_____ Bus Phone (_____)_____

Medical / Hospital Insurance Company_____ Phone (_____) _____

Policy Holder's Name_____ Policy Number_____

HEALTH INFORMATION ***(Please Print)***

Does the child have any of the following conditions or a history of any of the following conditions? (***Check all that apply***.)

☐ Asthma ☐ Bronchitis ☐ Fainting Spells
☐ Diabetes ☐ Ear Infections ☐ Heart or Cardio-Vascular Problems / Disease
☐ Convulsions / Seizure ☐ Hay Fever ☐ Chronic Bone, Muscle or Joint Injuries
☐ Migraine Headaches ☐ Other condition(s): (Please list) _____

Allergies or reactions: (***Check all that apply.***)

☐ Aspirin ☐ Penicillin ☐ Dairy ☐ Gluten ☐ Peanuts ☐ Other (list) _____
☐ Insect Bites or Stings ☐ Ivy / Oak / Sumac Toxins ☐ Other (list) _____

Is your child currently on any prescribed or over-the-counter medication? (If so, please record the condition / ailment, name of medication, dosage, time(s) of day, prescribing physician, etc.)

_____

_____

Date of last tetanus shot (*approximate if necessary*): _____

THIS AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT MUST BE COMPLETED BEFORE PARTICIPATION IN ANY CHRIST CHURCH, PRESBYTERIAN PROGRAM.

I, the undersigned parent / guardian of the above listed minor applicant / participant, acknowledge that each applicant / participant will be engaging in activities that involve risk of serious injury, including permanent disability or death, and that immediate emergency medical treatment and intervention may be required should such an injury occur. By my signature below I hereby GRANT A FULL TEMPORARY MEDICAL POWER OF ATTORNEY to the event director for Christ Church, Presbyterian, and authorize said person(s) to perform any and all acts necessary to obtain and secure medical treatment for my minor child of which I am the parent / guardian as if I were present, to and including treatment by paramedics, medical evacuations of all types as deemed medically necessary, and diagnostic procedures deemed medically necessary, surgeries if determined by a duly licensed medical doctor ot be medically necessary, as well as hospitalization in connection with any of the aforementioned procedures.

I hereby expressly hold harmless Christ Church, Presbyterian, Evans, Georgia, including any of its pastors, employees, elders, deacons, or others associated with Christ Church, Presbyterian, Evans, Georgia concerning the obtaining of emergency medical treatment for my child of which I am the parent / guardian, as well as waiving any legal cause of action I may have against Christ church, Presbyterian, Evans, Georgia in connection with their procuring said emergency medical services.

I further understand that Christ Church, Presbyterian, Evans, Georgia, is not financially responsible for the payment of any item of emergency medical services for which this authorization is granted, and that as the parent / guardian I am financially responsible for same.

This Medical Power of Attorney shall be valid through December 31, 2_____.

Executed this _____ day of _____, 2_____.

Parent / Guardian Printed Name _____

Parent / Guardian Signature _____