

PARTICIPANT FORM

NOTE: All Students and Leaders within NHBC Student Ministry must complete this form to be eligible to participate in any Student Ministry activities. Students under age 19 must have a parent’s or legal guardian’s signature, and everyone, regardless of age must have this form notarized. **ALL SECTIONS MUST BE COMPLETE IN THEIR ENTIRETY TO PARTICIPATE.** Please TEXT a copy (front and back) of your Insurance Card to Joey @ 864-903-2491. This form is for all 2018 NHBC Student Ministry Activities and will be kept on file in the church office.

NAME: (LAST) _____ (FIRST) _____ (MI) _____ DOB ___/___/___ AGE: ___ SEX ___
 GRADE COMPLETED IN 2018 _____ PARTICIPANT’S CELL# _____ PARTICIPANT’S EMAIL _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT’S INFORMATION FATHER’S NAME _____ CELL# _____ DOB ___/___/___
 MOTHER’S NAME _____ CELL# _____ DOB ___/___/___
 EMAIL _____ EMAIL _____

IN CASE OF AN EMERGENCY AND PARENTS CAN’T BE REACHED, CONTACT:

NAME _____ CELL# _____ DAY# _____ NIGHT# _____
 NAME _____ CELL# _____ DAY# _____ NIGHT# _____

MEDICAL PROFILE

GENERALLY, MY HEALTH IS: (CHECK ONE) EXCELLENT GOOD FAIR POOR

IF FAIR OR POOR, PLEASE EXPLAIN YOUR CONDITION _____

LIST ANY MEDICAL DIFFICULTIES THAT YOUR LEADERSHIP SHOULD KNOW ABOUT _____

LIST ANY MEDICATIONS THAT YOU TAKE ON A REGULAR BASIS AND WILL NEED TO BE TAKEN WHILE ON/DURING CHURCH SPONSORED TRIPS.

MEDICATION	DOSAGE	HOW OFTEN?
_____	_____	_____
_____	_____	_____
_____	_____	_____

DOES AN ADULT NEED TO ADMINISTER THE ABOVE PRESCRIPTION MEDICATIONS? _____

LIST ANY MEDICATIONS TO WHICH YOU/YOUR CHILD ARE ALLERGIC AND REACTIONS TO EACH

MEDICATION	REACTION
_____	_____
_____	_____
_____	_____

LIST ANY FOODS TO WHICH YOU/YOUR CHILD ARE ALLERGIC AND REACTIONS TO EACH. IF ACCIDENTALLY INGESTED OR TOUCHED, WHAT ACTIONS SHOULD BE TAKEN?

FOOD	REACTION	ACTION
_____	_____	_____
_____	_____	_____
_____	_____	_____

DOES NEW HOPE’S STAFF/LEADERS AND/OR CHAPERONES HAVE PERMISSION TO ADMINISTER OTC MEDICATIONS SUCH AS TYLENOL, ADVIL, BENEDRYL, COUGH/COLD MEDICINES, ETC? _____

REASON	MEDICATION	DOSAGE & HOW OFTEN?
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY PHYSICIAN: _____ ADDRESS _____
CITY _____ STATE _____ ZIP _____ PHONE NUMBER _____

DATE OF LAST TETANUS IMMUNIZATION: ____/____/____

INSURANCE COMPANY: _____ POLICY OR GROUP# _____
ADDRESS _____ CITY _____ ST _____ ZIP _____
SUBSCRIBER NAME: _____ SUBSCRIBER
NUMBER _____
PLACE OF EMPLOYMENT _____ OCCUPATION _____ WORK # _____

AUTHORIZATION FOR MEDICAL TREATMENT

I/WE, _____, OF _____ COUNTY, STATE OF _____,
AM/ARE THE CUSTODIAL PARENT(S) HAVING LEGAL CUSTODY OF _____, A MINOR CHILD,
AGE _____, BORN ____/____/____. I/WE AUTHORIZE NEW HOPE BAPTIST STUDENT MINISTRY IN WHOSE CARE THE
MINOR CHILD HAS BEEN ENTRUSTED, AND WHOSE OFFICE IS LOCATED AT 4010 KEOWEE SCHOOL RD, SENECA, SC 29672, TO DO ANY
ACTS WHICH MAY BE NECESSARY OR PROPER TO PROVIDE FOR EMERGENCY HEALTH CARE OF THE MINOR CHILD ON BEHALF OF THE
PARENT, LEGAL GUARDIAN, OR PERSON HAVING LEGAL CUSTODY OF THE CHILD, INCLUDING, BUT NOT LIMITED TO, THE POWER

1. TO PROVIDE FOR SUCH HEALTH CARE AT ANY HOSPITAL OR OTHER INSTITUTION, OR THE EMPLOYING OF ANY PHYSICIAN,
PSYCHIATRIST, DENTIST, NURSE, OR OTHER PERSON WHOSE SERVICES MAY BE NEEDED FOR SUCH HEALTH CARE, AND
2. TO CONSENT TO AND AUTHORIZE ANY HEALTH CARE, INCLUDING ADMINISTRATION OF ANESTHESIA, X-RAY, PERFORMANCE
OF OPERATIONS, AND OTHER PROCEDURES BY PHYSICIANS, DENTISTS, AND OTHER MEDICAL PERSONNEL EXCEPT THE
WITHHOLDING OR WITHDRAWAL OF LIFE SUSTAINING PROCEDURES.

THE UNDERSIGNED SHALL IMMEDIATELY BE NOTIFIED OF THE CHILD OF MEDICAL CARE BEING PROVIDED ON HIS/HER BEHALF. THIS
CONSENT SHALL BE EFFECTIVE FROM _____ 20____ THROUGH _____ 20____.

I/WE DO HEREBY AGREE TO HOLD NEW HOPE BAPTIST CHURCH, AND THEIR AGENTS AND EMPLOYEES, HARMLESS FROM ANY AND
ALL LIABILITY, ACTIONS, CAUSES OF ACTIONS, CLAIMS, EXPENSES, AND DAMAGES ON ACCOUNT OF INJURY TO MY/OUR OR
PROPERTY, EVEN INJURY RESULTING IN DEATH, WHICH I WE NOW HAVE, MY/OUR MINOR CHALD HAS, OR WHICH MAY ARISE IN THE
FUTURE IN CONNECTION WITH ANY MEDICAL TREATMENT DEEMED NECESSARY AND AUTHORIZED BY LARRY J HAWKINS JR IN HIS
EXERCISE OF THE TERMS OF THIS HEALTH CARE CONSENT FORM.

BY SIGNING BELOW, I INDICATE THAT I HAVE THE UNDERSTANDING AND CAPACITY TO COMMUNICATE HEALTH CARE DECISIONS AND
THAT I AM FULLY INFORMED AS TO THE CONTENTS OF THIS DOCUMENT AND UNDERSTAND THE FULL IMPORT OF THIS GRANT OF
POWERS TO THE AGENT NAMED HEREIN. I FUTHER STATE THAT **I HAVE CAREFULLY READ THE GOREGOING AUTHORIZATION TO
CONSENT TO HEALTH CARE FOR MINOR AND INDEMNIFICATION AGREEMENT AND KNOW THE CONTENTS THEREOF AND I SIGN
HEREUNDER AS MY OWN FREE ACT.**

SIGNATURE OF PARENT OR LEGAL GUARDIAN

PRINT SIGNATURE

DATE

PLEASE LIST NAMES OF ALL PERSONS AUTHORIZED TO PICK YOUR CHILD UP AT THE END OF ACTIVITIES/EVENTS

NAME

RELATIONSHIP

SIGNATURE

PRINT SIGNATURE

DATE

On this _____ day of _____ 20____, in the state of South Carolina, in the county of Oconee, the above
(DAY) (MONTH) (YEAR)

signed personally appeared before me and in my presence executed the within and foregoing permission and release
form. Witness my hand and official seal on this day _____ of _____ of 20____.
(DAY) (MONTH) (YEAR)

NOTARY NAME: _____ NOTARY SIGNATURE _____
PLEASE PRINT

My commission expires: _____

SEAL: