NEW HOPE BAPTIST STUDENT MINISTRY – 4010 KEOWEE SCHOOL RD, SENECA, SC 29672 864-882-0828

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 @ 864-973-1454. This form is for all 2019-2020 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? _____ _____. SPECIFY REASON & OTC MEDS TO GIVE YOUR CHILD
YES OR NO YOUR INITIALS

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 IMMEDIATGELY 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 TREATEMENT 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: