

Medical Release Form (student)

District Blitz Conference, April 19-21, 2024

Because of the increasing sophistication of our hospital systems, we have found it necessary to have signed parental release forms in the unlikely event of some serious injury requiring hospital treatment. Since many hospitals will not administer any medical treatment to a minor without some parental consent, this release form gives us permission to take your child to the nearest available medical facility and have the necessary medical treatment administered.

Parents/Guardians please read and sign the statement below. This provides permission to seek whatever medical attention may be necessary. It also releases North Central District of the Evangelical Free Church of America, CNC (Converge North Central), Trout Lake Camps, and / or the church's personnel from any liability against personal injury or loss.

We understand the arrangements and believe that necessary precautions and plans for the care and supervision of the child will be taken during this conference. Beyond this, we will not hold responsible North Central District of the Evangelical Free Church, CNC (Converge North Central), Trout Lake Camps, or any of the conference staff. In case of emergency, I understand that every effort will be made to contact me. If I cannot be reached, I hereby give the Student Ministries Conference leadership, staff or other emergency medical personnel the permission to act on my behalf in seeking emergency medical treatment for this child in the event that such treatment is deemed necessary by the conference or church staff. I give permission to those administering emergency medical treatment to do so using those measures deemed necessary. I absolve the North Central District of the Evangelical Free Church, CNC (Converge North Central), Trout Lake Camps, and/or church personnel from liability in acting on my behalf in this regard, so long as they are not grossly negligent.

Name of Child: _____

Signature of Parent / Guardian: _____ Date: _____

Primary Phone: _____ Secondary Phone: _____

Insurance Company: _____ Policy Number: _____

If Parent / Guardian are not available, please call person below:

Name: _____ Relationship to Student _____

Primary Phone: _____ Secondary Phone: _____

May we administer over-the-counter medications? (e.g., aspirin, Tylenol, Advil, antibiotic ointments, etc.) _____

Additional comments regarding medical history, allergies, penicillin, drug reactions, use of over-the-counter medications, etc., that may be needed in treatment: _____