Medical Release Form (adult)

District Blitz Conference, April 19-21, 2024

Because of the increasing sophistication of our hospital systems, we have found it necessary to have all attending youth leaders and adults provide the District Blitz Conference with a release form in the unlikely event of some serious injury requiring hospital treatment. This release gives us permission to provide a quick response to any medical treatment that may need to be administered.

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.

I understand the arrangements and believe that the necessary precautions and plans for my care will be dealt with and handled well and in a professional and timely manner. Beyond this, I will not hold responsible North Central District of the Evangelical Free Church of America, CNC (Converge North Central), Trout Lake Camps, and/or any of the conference staff. In case of emergency I understand that every effort will be made to contact my emergency contact. If they cannot be reached, I hereby give the District Blitz Conference leadership, staff or other emergency medical personnel the permission to act on my behalf in seeking emergency medical treatment in the event that such treatment is deemed necessary by the conference 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 of America, 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 Adult Leader: _____

Insurance Company: _____ Policy Number: _____

In case of an emergency, please contact:

Name:_____ Primary Phone:_____ Secondary Phone:_____

Relationship to Adult: _____

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

Signature: _____ Date: _____