NEWSONG YOUTH

Annual Youth Ministry Parent/Guardian/Conservator Permission, Liability Waiver, and Medical Information

Participant's Name	Birth Date	Relationship	Address	City/State/Zip

Parent/Guardian/Conservator's Name: _____

Home Address: _____

Cell Phone: _____ **Business Phone:** _____

Text: Yes___ No___ **E-mail:** _____

I, _____, grant my permission for the above participant(s) to participate with the various programs and activities of New Song Evangelical Free Church, beginning the first day of January, 2016 and continuing through the thirty-first day of December, 2016. These various programs and activities will take place under the guidance and direction of employees and/or volunteers from New Song Church. This permission and liability waiver will be kept on file.

I understand that as a parent/guardian/conservator, I remain legally responsible for any personal actions taken by the participant(s) named above.

I agree on behalf of myself, my son(s)/daughter(s)/participant(s) herein, our/his/her/their heirs, and assign to hold harmless New Song Evangelical Free Church, its employees, agents, and volunteers from any and all claims (unless due in party by gross negligence of New Song Evangelical Free Church) for illness, injury, death, and the cost of medical treatment therewith, arising from or in any way connected with any of the above participant's attending the various programs and activities during the dates named above.

Parent/Guardian/Conservator Signature: _____ **Date:** _____

Emergency Contacts

Please list the people you would like to be notified in case of emergency.

In case of emergency, contact:

Contact 1:

Name & Relationship: _____

Address: _____ City/State/ZIP: _____

Phone: _____ Cell: _____

Contact 2:

Name & Relationship: _____

Address: _____ City/State/ZIP: _____

Phone: _____ Cell: _____

The personal information requested on this form is confidential. In the event of a medical emergency, this information will be used by authorized emergency personnel. In case of emergency, I give my permission for the above participant(s)' information to be released to emergency personnel. I also agree that any of my emergency contacts listed may be notified in an emergency as needed.

Parent/Guardian/Conservator Signature: _____ Date: _____

Printed Name: _____ Relationship to Participants:_____

Social Media Release

I also consent to the use of any videos, photos, or any other visual or audio reproduction (in perpetuity unless otherwise revoked by me in writing and delivered by certified mail, return receipt requested, to: New Song Church, 151 East Briarcliff Rd, Bolingbrook, IL 60440, ATTN: Pastor of Youth Ministries) in which the above named participants may appear by New Song Evangelical Free Church. I understand that these materials are being used for promotion of the youth ministry of New Song Evangelical Free Church which may include recruitment and fundraising efforts.

Parent/Guardian/Conservator Signature: _____ Date: _____

Child's Name:_____

Student Medical Waiver

Participant Medical Information: Please attach a photocopy of your (participant's) Insurance Card (front and back) and fill out the information below. Name of Policy Holder (whose name is the policy in)_____
Insurance Carrier: _____Policy Number: _____
Insurance ID Number: _____

Prescription Medications: Check Box 1, 2, or 3 which is true for your child – DO NOT CHECK ALL BOXES

☐ 1. This child takes no medication and will bring no medication with him/her.

☐ 2. This child takes medication(s) and will self-medicate. The child will bring all such medications necessary, and such medications will be clearly labeled. I understand that the child will be required to turn all medication(s) over to a supervising adult designated to keep medication(s), unless I provide a signed and dated note stating (1) what the medication is, (2) how much medication this child is bringing, and (3) when this child is to take the medication. If no note is provided, I further understand that it will be this child's responsibility to present himself/herself at a location designated for returning medication(s) to this child at the frequencies and times listed below. I understand that the adult to whom this child surrenders the medication has no medical training, and this adult will not measure dosages. This child will return the medication(s) to the adult after he/she self-medicates, unless I send a note authorizing this child to retain his/her medication. At the conclusion of the event, it will be this child's responsibility to pick up remaining medication(s), if any, at the self-medication designated location. Names of medications and exact dosage and frequencies/times are as listed below: (you may attach a sheet to this form if you need more space, just make sure to sign and date it as well).

_____

_____

☐ 3. This child takes medication but is unable to self-medicate. The child's parent/guardian/conservator will provide and dispense any and all needed medications.

Non-Prescription Medications: Check Box A or B. DO NOT CHECK BOTH BOXES

☐ A. No medication of any type whether prescription or nonprescription may be administered to this child unless the situation is life-threatening and emergency treatment is required.

☐ B. I grant permission for the following nonprescription medication to be given to this child (excluding medication listed below that causes allergic reaction).

Non-aspirin pain reliever:	Yes____ No_____	# of tablets per dosage_____
Throat Lozenge:	Yes____ No_____	# of tablets per dosage_____
Decongestant:	Yes____ No_____	# of tablets per dosage_____
Antacid:	Yes____ No_____	# of tablets per dosage_____
Antihistamine:	Yes____ No_____	# of tablets per dosage_____

Specific Medical Information:

_____

Allergic Reactions (medications, foods, plants, insects, etc.)

_____

Immunizations: date of last tetanus/diphtheria immunization

_____

Other medications child currently takes

_____

Any physical limitations

_____

Has child recently been exposed to any contagious disease or condition such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition.

_____

You should also be aware of these special medical conditions of this child. Please attach a clear description to this form.

To the best of my ability, everything I have stated here is true and accurately reflects my wishes.

⇨ **Parent/Guardian/Conservator Signature**_____ **Date** _____