

CONSENT FOR MEDICAL TREATMENT & WAIVER OF LIABILITY SALEM FIRST CHURCH OF THE NAZARENE (ADULT: 2016)

I, _____

do hereby consent to accept personal responsibility and liability for activities I may choose to participate in, including associated travel, with the Salem First Church of the Nazarene (the Church) of Salem, Oregon, USA, on January 1, 2016, through and including December 31, 2016.

I understand that some or all of the activities in which I may participate involve a certain element of risk, either from the activity itself and/or in the transportation to and from the activity. However, I wish to participate in the activities despite the potential risks and wish to assume those risks myself. I agree to hold harmless the Church for costs associated with any injury or accident, including transportation by ambulance or other conveyance.

I understand and agree that any insurance carried by the Salem First Church of the Nazarene that may be available for help in covering the cost of injuries or accidents will only be applied, if appropriate, after the policy limits on my own policy have been used to the full extent.

I hereby waive and release the Church, its staff, and all persons involved in organizing or leading the activity from liability, corporate or personal, arising from injuries associated with said activity.

I do hereby consent and grant to the pastor/persons in charge full right and authority to act for me in any matter pertaining to emergency care I may require if I am unable to do so. In such a case where I am unable to name or secure my own physician I grant authority to the physician selected by the pastor or lay person in charge to hospitalize and secure proper treatment including, but not limited to, injections, anesthesia, x-rays, surgery, or dental care as he/she may feel necessary to treat my injuries in a timely fashion.

Participant's Signature Date

Participant's Name (please print)

Emergency telephone numbers: (please specify: cell, home, work... etc.) provide 2 contact numbers for use in an emergency or other urgent need.

1st -
Name _____ Phone _____
Relationship _____

2nd -
Name _____ Phone _____
Relationship _____

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Participant's Full Name _____ Birthdate _____

Home Address _____

City _____ State _____ Zip _____

Local Doctor's Name _____ Phone _____

Medical Insurance Company Information

Name of Company _____

Mailing Address _____

Policy or Group Number _____ Phone _____

Please answer ALL of the following questions and give any other pertinent medical information.

YES / NO 1. Are you presently under treatment for any medical problems? _____

YES / NO 2. Do you take any medications routinely?
If yes, name medications & schedule _____

YES / NO 3. Have you ever been unconscious or had any head injuries?
If yes, give dates & situation _____

YES / NO 4. Are you allergic to any medications or certain types of food?
If yes, please name them _____

YES / NO 5. Have you ever had asthma, hay fever, hives, or eczema? _____
(If yes, please send an ample supply of medication with the minor for the event.)

YES / NO 6. Do you have a history of diabetes or heart disease? _____

YES / NO 7. Have you had any recent illness, skin rashes, or sore throats?
If yes, please explain _____

YES / NO 8. Do you require any injections (allergy or other) on a regular basis?
If yes, please explain _____

YES / NO 9. Date of last Tetanus shot _____

Additional Notes:

Participant's Signature _____

Date _____

Participant's Name (please print) _____