Medical Information, Emergency Contact Info & Medical Consent Form
Hanover Community Church

____
Printed Name of Parent or Guardian

Contact Phone Home:_______________________________ Cell:_______________________________

Address: ____

I, the undersigned, certify that I am the parent or guardian of ____

(hereafter the "minor child") born on __________________________.
mm/dd/yyyy

My signature as the parent or guardian of above named minor child at each item below indicates my consent:

I hereby consent to allow my minor child participate in the following activity of Hanover Community Church:
Challenge Camp (hereafter the "activity")

from June 14 through June 18, 2010 including any transportation that may be necessary to and from the activity venue.

Signature & Date ____

I recognize that there are risks involved in participating in this activity and hereby assume all risk of injury, harm, damage, or death to my minor child in connection with his/her participation in this activity. It is understood that every reasonable precaution will be taken for the safety and well-being of my child and to the fullest extent permitted by law, I release Hanover Community Church, its trustees, officers, directors, employees, agents and representatives from any injury, harm, damage or death which may occur to my minor child while participating in the activity and agree to release and hold harmless Hanover Community Church, its trustees, officers, directors, employees, agents and representatives from any claims arising out of my minor child's participation in the activity.

Signature & Date ____

In case of medical emergency, I understand that hospital policy requires parental permission before treatment. In the event I cannot be reached in an emergency, I herby give permission to the physician selected by a Hanover Community Church representative to hospitalize and secure proper treatment for my child. I have provided Hanover Community Church with a medical information form for my child including emergency contact information. I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician or surgeon for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist for my child. I further agree to pay all charges for the dental, medical, or hospital care or treatment. As parent or legal guardian of my child, I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the dental, medical, or hospital care or treatment to be rendered to my child is legally sufficient and that no consent from any other person is required by law.

Signature & Date ____

I grant Hanover Community Church the right to photograph my child and the right to use such photographs, videos and reproductions with or without name or with a fictitious name, in any manner in connection with the advertising program of Hanover Community Church. I waive all right of inspection and approval, and release Hanover Community Church from any and all liability arising out of exercise of the rights hereby granted.

Signature & Date ____

----------OR-----------

I DO NOT grant Hanover Community Church permission for my child to be photographed or videoed in any manner in connection with the advertising program of Hanover Community Church.

Signature & Date ____

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Every block on this page must be completed in full. If the area does not apply, mark N/A. Attach a separate sheet if necessary.

Child's Name	Birthdate
Street Address	City, State, Zip
Mother/Legal Guardian Name	Contact Phone Number(s)
Street Address (if different than child)	City, State, Zip
Father/Legal Guardian Name	Contact Phone Number(s)
Street Address (if different than child)	
Emergency Contact Person (if parent cannot be reached)	Contact Phone Number(s)
Emergency Contact Person (if parent cannot be reached)	Contact Phone Number(s)
Emergency Contact Person ((if parent cannot be reached)	Contact Phone Number(s)
Health Insurance for Child or Medical Assistance Benefits	Policy Number (Required)
Name of Child's Physician	Physician Phone Number
Street Address	City, State, Zip
Medical or Dietary Information Necessary in an Emergency	Date of last tetanus shot
Medication that your child is currently taking	
Allergies: bee stings pollens hay/straw penicillin other, describe & indicate if life threatening	
Has child ever had: seizures asthma diabetes heart disease homesickness other, describe	
Disabilities – describe physical, emotional, mental, behavioral or other	

In case of medical emergency, I understand that hospital policy requires parental permission before treatment. In the event I cannot be reached in an emergency, I herby give permission to the physician selected by a Hanover Community Church adult representative to hospitalize and secure proper treatment for my child.

I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician or surgeon licensed under the provisions of the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the provisions of the Dental Practice Act for my child. It is understood that the church, its officers, pastors, counselors, leaders, or agents will not be held liable for any first-aid rendered, or treatment, drugs, or medicines administered, or surgical procedure performed pursuant to this consent. I further agree to pay all charges for the dental, medical, or hospital care or treatment.

As parent or legal guardian of my child, I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the dental, medical, or hospital care or treatment to be rendered to my child is legally sufficient and that no consent from any other person is required by law.

Signature of Parent or Legal Guardian	Date
Printed Name	

Periodic Review

Signature of Parent or Legal Guardian	Date
Signature of Parent or Legal Guardian	Date
Signature of Parent or Legal Guardian	Date
Signature of Parent or Legal Guardian	Date

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Complete this page **only** if you are bringing medication to be administered to your child.
Medication must be in its original package that shows child's name.

Child's Name	Date of Birth
Medication	Dosage
Prescription Non-prescription	Refrigeration Required: yes no
If Prescription, Prescriber's Name	Prescriber's Telephone Number
Dosage Amount	Time to Administer
Number of times per day to administer	Dates to Administer
Special instructions i.e. symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications:	
I give permission to Hanover Community Church to administer medication to my child as stated above. Parent Signature: Date:	

OFFICE USE ONLY				
Date Administered	Time Administered include AM or PM	Amount Administered	Comments/Reactions	Initials