

CONSENT FORM

Participation and Medical Treatment

Student Last Name _____ First _____

I give my consent for this child in my care to participate in **The 2011 Northeastern Iowa Synod LYO Assembly**

traveling to **The Holiday Inn in Mason City, Iowa** under the supervision of _____ (Primary Leader)
on the dates **March 5-6, 2011**.

Parents/Guardians _____ Address: _____

City: _____ State: _____ Zip code _____

Daytime Phone (home or work) _____ - _____ - _____ Evening Phone (home or cell) _____ - _____ - _____

Other Parent/Guardian _____ Address (if different) _____

City: _____ State: _____ Zip code _____

Daytime Phone (home or work) _____ - _____ - _____ Evening Phone (home or cell) _____ - _____ - _____

In Case of Emergency call: _____ at _____ - _____ - _____

Does Student have insurance? Yes _____ No _____ Insurance Company Name _____

Name Insured under _____ Policy Number _____ Group # _____

Physician Name _____ Physician Phone Number _____ - _____ - _____

Student Health History (check or list)

_____ Diabetes
_____ ADD/ADHD
_____ Asthma
_____ Epilepsy
_____ Cardiac Problems
_____ Eating disorders/conditions
_____ Orthopedic Problems _____

Allergies: (check or list)

_____ Aspirin
_____ Penicillin
_____ Sulfa
_____ Insect Bites
_____ Tetracycline
_____ Acetaminophen
_____ Foods
_____ Other (explain) _____

List any medications your child is currently taking, the purpose and dosage/frequency:

-Over-

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Explain any allergies or allergic reactions your child may have (food, medications, etc.) and treatment generally given:

Do we have permission to administer to your child? (Check those allowed). ___ Aspirin ___ Tylenol ___ Ibuprofen ___ Acetaminophen

Has our child had a tetanus shot within the last 6 years: ___ No ___ Yes Date_____

Do you know of any health factors that make it advisable for your child to follow a limited program of physical activity or from participating in any activities? ___ No ___ Yes Explain: _____

MEDICAL CONSENT:

I give my permission to administer prescription medications listed on the form above. I will provide all Medication in **original** containers. Photocopies of prescriptions are required so they can be easily replaced if lost.

I give my permission to the physician, hospital or emergency team to secure proper treatment & to order medications, injections, anesthesia or surgery for my child named above. I understand the staff, chaperones or director will make every attempt to contact myself or other emergency contacts listed above regarding my child's condition.

I (we) also release the participant's name as part of an information database for the synod and ELCA related entities, and that photos/videos produced by the synod become property of the synod and can be used for ELCA related purposes and publicity including the Synod's web site.

Parent/Guardian signature _____ Relationship to student _____ Date _____

Student Signature _____ Date _____

Notary Signature _____ Date _____ Stamp: