

# CONSENT FORM

## Participation and Medical Treatment

Student Last Name \_\_\_\_\_ First \_\_\_\_\_

I give my consent for this child in my care to participate in \_\_\_\_\_ (event)  
traveling to \_\_\_\_\_ (place) under the supervision of \_\_\_\_\_ (Primary Leader)  
on the dates: \_\_\_\_\_.

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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

Has your 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: \_\_\_\_\_

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**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: