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:

_____

_____

_____

-Over-

CONSENT FORM
Participation and Medical Treatment
Page 2

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 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: _____

_____

_____

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:*