MEDICALCONSENT AND LIABILITY RELEASE FORM

Must be completed and carried by all participants. Copy must be given to group leader. Must be signed by parent or guardian of participants under 21 years of age. Please type or print legibly in ink.

Participant Name: _____
(Last) (First)

Birth Date:
_____/____/_____Male_____Female_____SS#_____

Home Address: _____

City/State/Zip: _____

Home Phone: (____)_____Day Phone: (____)_____

Custodial Parent/Guardian: _____

Home Phone: (____)_____Day Phone: (____)_____

Home Address (If Different): _____

Health Plan Carrier: _____

Name of Insured: _____

Relationship To Participant: _____

SS# or Policy Holder or Insurance ID Number: _____

Family Doctor: _____

Office Phone: (____)_____Medical Exchange: (____)_____

Family Dentist: _____Office Phone: (____)_____

Second Parent or Emergency Contact Person: _____

Relationship To Participant: _____

Home Phone: (____)_____ Day Phone (____)_____

Please specify if any health insurance precertification, notification, or other requirements exist for the participant:

Medical Card Copy Front Medical Card Copy Back

CONSENT CONTINUED

I understand that the Servant Event for which this Medical Consent and Liability and Activity Release Form is being given is described as follows:

The HARP Mission • 810 Main Street • Caldwell, OH 43724

(Providing light home repairs, maintenance, painting, yard work, wheelchair ramps, cleaning and other home chores for low-income, elderly, veterans, disabled and other families and individuals in need)

I hereby consent to participation of myself (or of my child) in the above-described Servant Event. I have read the informational materials regarding the planned activities. I am aware that in addition to activities such as Bible study, worship, sight-seeing, using public transportation and meal functions, the participants also may be asked to participate in various servant activities that may involve additional risks, such as:

_____

_____

I understand that I have a duty to provide primary accident and medical insurance for myself (or for my child) and I declare that I am (or my child is) covered by primary accident and medical insurance.

I REALEASE AND FOREVER DISCHARGE_____,
(Name of Home Congregation)
AND The HARP Mission in Caldwell, OH,
THEIR AGENTS AND SERVANTS, SUCCESSORS, AND ASSIGNS, DIRECTORS, TRUSTEES, OFFICERS, EMPLOYEES AND OTHER REPRESENTATIVES FROM ANY AND ALL DAMAGES FROM MY (OR MY CHILD'S) PARTICIPATION IN, ATTENDANCE AT AND TRAVEL TO AND FROM THE SERVANT EVENT. FURTHERMORE, I DO HEREBY EXPRESSLY STIPULATE, AND AGREE TO INDEMNIFY AND HOLD FOREVER HARMLESS, THE

_____(Name of Home Congregation)

AND The HARP Mission in Caldwell, OH,
ITS AGENTS AND SERVANTS, SUCCESSORS AND ASSIGNS, DIRECTORS, TRUSTEES, OFFICERS, EMPLOYEES, AND OTHER REPRESENTATIVES AGAINST LOSS FROM ANY AND ALL PRESENT OR FUTURE CLAIMS, DEMANDS, OR ACTIONS IN LAW OR IN EQUITY THAT MAY HEREAFTER BE MADE OR BROUGHT BY ME OR MY CHILD, OR BY ANYONE ELSE ON THEIR OWN BEHALF FOR DAMAGES OR ANY OTHER LEGAL OR EQUITABLE REMEDY ON ACCOUNT OF ANY INJURY, ILLNESS, PHYSICAL CONDITION, INCONVENIENCE, OR LOSS SUSTAINED BY ME OR MY CHILD DURING THE SERVANT EVENT OR TRAVEL TO AND FROM THE SAME.

I, the undersigned, hereby acknowledge that I have read the foregoing, understand its contents, and have signed the same as my own free act and deed.
FOR PARTICIPANTS AGE 21 AND OVER:

_____

Participant Signature *Date* *Witness*

FOR PARTICIPANTS UNDER AGE 21:

_____

Parent/Guardian *Date* *Witness*

AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE

Must be completed by parents or guardians of participants under 21 years of age. Parent/Guardian signature must appear below or your child will not be permitted to attend the Servant Event.

(I) (We), the undersigned parent(s) and/or natural guardian(s) of _____ (Social Security#_____), a minor, do hereby authorize my (our) child's Servant Event youth leader (and/or any other adult appointed or designated) to (i) consent to medical, surgical, and dental care for such minor child, (ii) consent to any diagnostic tests, medical, surgical, or dental procedure or treatment as may be considered therapeutically necessary by the physician, surgeon, dentist, or other health care personnel providing care for such minor child, and (iii) on (my) (our) behalf, to (a) employ physicians, surgeons, dentists, nurses, and other health care personnel as may be deemed necessary for such minor child, (b) admit such minor child to any hospital, clinic, emergency room, laboratory, or other health care or diagnostic facility for examination, treatment, surgery, or care, and (c) sign all necessary consents and authorizations. It is understood that this authorization is given in advance of the occurrence of any condition or situation that would necessitate any such medical, surgical, or dental care being required but is given to provide authority to obtain such care if it should be required. I fully understand the consequences of the foregoing statements and sign this AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE knowingly, freely, and willingly.
This authorization shall continue for such time as my child is participating in the Servant Event and during travel to and from the Servant Event.

IN WITNESS WHEREOF, (I) (We) have executed this "Authorization to Consent to Medical and Dental Care" this _____ day of 20_____.

_____

Parent/Legal Guardian Signature *Date*

_____

Parent/Legal Guardian Signature *Date*

STATE OF_____COUNTY OF_____

On this _____day of 20_____, before me, a Notary Public, personally appeared and known to me to be the person(s) who executed the above Consent and stated that it was executed as his/her (their) free act and deed.

Notary Public

(NOTARY SEAL)

EMERGENCY MEDICAL INFORMATION FORM

Please complete so that health providers can be aware of your personal health needs.
Must be completed by all Servant Event participants.

Name of
Participant_____

Does participant have (if "yes" explain):
Yes No Allergies?_____
Yes No Heart Condition?_____
Yes No Other?_____

Is participant subject to (if "yes" explain):
Yes No Headaches?_____
Yes No Seizures?_____
Yes No Motion Sickness?_____
Yes No Fainting?_____
Yes No Sleepwalking?_____
Yes No Upset Stomach?_____
Yes No Other?_____

Does participant have reaction to (if "yes" explain):
Yes No Bee Sting?_____
Yes No Penicillin?_____
Yes No Other Drugs?_____
Yes No Poison Ivy, Oak, Sumac?_____
Yes No Other?_____
Yes No Has the participant had any serious illness or surgery within the past 10 years?
Please List:_____
Yes No Does the participant have any condition that would prevent him/her from participating in any Servant Event activities?
Please List:_____
Yes No Are any drugs ineffective in treatment?
Yes No Is the participant diabetic? Medication?
Yes No Does the participant have any sight or hearing impairment?
Yes No Does the participant wear contact lenses?
Yes No Does the participant wear hearing aids?

Blood Type:_____Date of last tetanus shot_____
A current tetanus shot is required. After 5 years, another tetanus shot is recommended.
Please indicate ANYTHING else that leaders should know to help avoid or deal with any medical situation that might arise:

_____

_____

_____