Risen Savior Lutheran Church
6770 E. 34th St. N.
Wichita, KS 67226
316-683-5538

Youth Medical Information and Consent and Liability Release Form and Authorization to Consent to Medical and Dental Care

Last Name of Participant ________ First Name of Participant ________ Day Phone of Custodial Parent/Guardian ________

______ Male
______ Female ______ DOB ________ Evening Phone of Custodial Parent/Guardian

Name of Custodial Parent/Guardian ________ Home Address ________ City ________ State ________ Zip ________

Name of Second Custodial Parent or Emergency Contact ________ Relationship to Participant ________ Day & Evening phone ________

Health Plan Carrier ________ Name of Insured ________ Policy Holder/Insurance ID# ________

Relationship to Participant ________ Name of Family Doctor ________ Phone Number ________

Medical Exchange ________ Name of Family Dentist ________ Phone Number ________

Date of Last Tetanus Shot ________ (A Current Tetanus Shot is Required) Blood Type ________

______ Yes ______ No Does your health insurance require pre-certification or notification for the health participant? If so, please list phone #: ________

______ Yes ______ No Does your health insurance have a preferred local Hospital for the health participant? If so, please list Name of Hospital: ________

Please provide a copy of the front and back of Participant's/Cardholder's Insurance Card. This form must be completed and carried by Participant and a copy given to Group Leader. This form must be signed by Custodial Parent/Guardian of Participant if under 18.

Emergency and Health Information

Does the Participant have: (If "Yes", please explain)

Yes	No	Condition	Explanation
______ Yes	______ No	Allergies?	________
______ Yes	______ No	Heart Condition?	________
______ Yes	______ No	Asthma?	________
______ Yes	______ No	Hearing Impairment?	________
______ Yes	______ No	Eyesight Impairment?	________
______ Yes	______ No	Contact Lenses?	________
______ Yes	______ No	Other?	________

Is the Participant subject to: (If "Yes", please explain)

Yes	No	Condition	Explanation
______ Yes	______ No	Fainting?	________
______ Yes	______ No	Sleep Walking?	________
______ Yes	______ No	Upset Stomach?	________
______ Yes	______ No	Headaches?	________
______ Yes	______ No	Motion Sickness?	________
______ Yes	______ No	Seizures?	________
______ Yes	______ No	Other?	________

(OVER)

Does the Participant have a reaction to: (If "Yes", please explain)

________ Yes	________ No	Bee Sting?	________
________ Yes	________ No	Penicillin?	________
________ Yes	________ No	Other drugs?	________
________ Yes	________ No	Poison ivy, oak or sumac?	________
________ Yes	________ No	Other?	________
________ Yes	________ No	Any Serious Illness or Surgery within the past 10 years? Please list:	________
________ Yes	________ No	Any Condition that would prevent Participant from participating in ANY Risen Savior or Kansas District Event? Please list:	________
________ Yes	________ No	Does Participant take any Prescription Medication? Please list:	________
________ Yes	________ No	Are any Drugs ineffective in treatment? Please list:	________

Please indicate ANYTHING else that the Leaders should know about Participant to help avoid or deal with any medical situation that may arise: ________

The Staff and Youth Leaders of Risen Savior Lutheran Church have my/our permission to give Participant any of the following:

________ Yes	________ No	Robitussin (cough medication)
________ Yes	________ No	Acetominophen (Tylenol)
________ Yes	________ No	Diphenhydramine (Benadryl)
________ Yes	________ No	Topical Antibiotic Ointment
________ Yes	________ No	Immodium (Anti-diarrheal)
________ Yes	________ No	Emetrol (Formula EM for Nausea)
________ Yes	________ No	Cold Medications (Dayquil)
________ Yes	________ No	Dramamine (motion sickness)
________ Yes	________ No	Ibuprofen (Advil, Motrin)
________ Yes	________ No	Topical Cortisone (Cortaid)
________ Yes	________ No	Solarcaine Spray/lotion/ointment
________ Yes	________ No	Midol
________ Yes	________ No	Antacid (Rolaids, Mylanta, etc.)

Emergency Procedure: In the event of any emergency, (I) (We) do hereby authorize Risen Savior Lutheran Church Adult Leaders, (and/or any other Adult appointed or designated by him/her) to: (i) consent to medical, surgical, and dental care; (ii) consent to any diagnostic tests, medical, surgical, or dental procedure or treatment therapeutically necessary by physician, surgeon, dentist, or other health care provider; and (iii) to (a) employ physicians, surgeons, dentists, nurses, and other health care personnel, (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 which would necessitate any such medical, surgical, or dental care required, but is given to provide authority to obtain such care if it should be required. (I) (We) fully understand the consequences of the foregoing statements and sign the **AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE** knowingly, freely, and willingly.

This authorization shall continue for such time (my) (our) child is participating in the Kansas District LCMS and/or Risen Savior Lutheran Church events and during travel to and from the Kansas District LCMS and/or Risen Savior Lutheran Church events. 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.

(SIGN NEXT PAGE)

IN WITNESS WHEREOF, (I) (We) have executed this "Authorization to Consent to Medical and Dental Care"
this ________ day of ________________, 20 ________. This form shall be valid through September 20 ________.

____
Name of Participant

____
Parent/Legal Guardian Signature

____
Parent/Legal Guardian Signature

STATE OF

SS

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.

(SEAL)

____
Notary Public