

Form XXIIIF
Medical Information, Consent to Medical Treatment and Release
Teen Participant

Event: _____

Group Leader: _____ Group Name: _____

Participants Name: _____ M/F: _____ Date of Birth: _____

Name of Parent(s): _____

Home Address(es): _____

Phone Numbers: Day: () _____ Evening: () _____

Medical Information

Primary Doctor: _____ Phone: () _____

My son or daughter will use the following medications:

Name of Medication(s): _____ Nature of Medication(s): _____

Prescribing Physician: _____ Phone: () _____

***All medications must be presented to adult chaperone before departure, in its original container,**

labeled with child's name and dosage information.

***If child must have medication with him/her at all times, please indicate the specific reason.**

Please identify any medical condition(s) your child has: _____

Allergies to medicine(s): _____

Other Allergies: _____

Insurance Carrier: _____ Plan: _____ Policy #: _____

You must have your insurance card with you at all times.

EMERGENCY MEDICAL TREATMENT

*By reason of our son/daughter being on a group trip, we as parents/guardians of the minor named above hereby consent and give our permission for our child to be diagnosed, treated, and/or medicated in accordance with standard medical practice, by licensed medical personnel.

*I/We hereby release any and all claims against _____ Church, the Youth Group of _____ Church, the Diocese of Camden, New Jersey, and their respective agents, servants, employees, officers, trustees, administrators and volunteers, for damages and/or injuries to us or to our child which may arise from medical treatment.

*I/We agree to indemnify and hold harmless _____ Church, the Youth Group of _____ Church, the Diocese of Camden, New Jersey and their respective agents, servants, employees, officers, trustees, administrators and volunteers, from and against any claim or claims brought by or on behalf of our child or by or on behalf of any other person arising out of or in any way connected with such medical treatment.

*I/We agree to accept any and all financial responsibility as a result of such treatment and the scheduling of such treatment.

Parent(s) Signature(s): _____

Print Parent(s) Name(s): _____

Date: _____

In the event of an emergency, if you are unable to reach me at the above number, contact:

Name: _____ Relationship: _____

Telephone #: () _____

INSURANCE:

Carrier and Plan: _____ Policy Number: _____