Participant Health History Form and Medical Treatment Authorization

Participant's Name: _____ Grade: _____ Gender: _____

Participant's Mother/Father/Guardian: _____ Parent/Guardian Phone: _____

Physician Name (printed): _____ Phone: _____

Health Insurance Company Covering Participant _____ Policy Number _____

Does the Participant have any of the following health conditions?

Please Check All That Apply

	Condition	Yes	No			Condition	Yes	No	
1	Asthma			Inhaler? Yes No	6	Allergies*			
2	Diabetes				7	Bee Sting Allergy			Epi Pen? Yes No
3	Epilepsy/Seizures				8	Food Allergy			Epi Pen? Yes No
4	Heart Condition				9	Peanut/Nut Allergy			Epi Pen? Yes No
5	Orthopedic								

- Is the Participant presently being treated for an injury or sickness or taking any form of medication for any reason? Yes__ No ___ (if yes, please explain) _____
- Please list medications, foods, or environmental allergens that Participant is allergic to and what reaction to allergy is if not mentioned above: _____
- Does the Participant sleep walk? Yes____ No____
- Can the Participant swim? Yes____ No____
- Does the Participant have any physical condition or illness which would prevent him/her from participating in normal rigorous activity? Yes_____ No_____ (if yes, please explain) _____
- Please list any and all diseases, serious illness, injuries and surgeries the Participant has or has had: _____
- Does the Participant require any medications to be administered? Yes____ No____ If yes, please list all medications with dosage, times and reason for dispensing: _____ _____

Permission is given for the following over-the-counter medications to be given to Participant as needed (check box) **[MUST HAVE PHYSICIAN'S SIGNATURE BELOW FOR AUTHORIZATION]:**

- ☐ Acetaminophen (as directed per age/weight)
- ☐ Ibuprofen (as directed per age/weight)
- ☐ Benadryl (as directed per age/weight)
- ☐ Zyrtec 10mg (as directed)
- ☐ Antiemetic (Dramamine, meclizine)
- ☐ Antacid (Tums, etc.)

Any personal medications (prescription and/or over-the-counter), vitamins, herbs, essential oils and enzymes MUST have a separate doctor's order and be brought in the original bottle to the first aid station at check-in to be administered to Participant.

This authorization shall remain in effect from the date of execution of this authorization through December 31, 2018, and shall be valid for any and all JRC activities in which the Participant is participating.

Medical Treatment Authorization

We, the parents and/or guardians of Participant, understand that we will be notified in the case of a medical emergency involving the Participant. However, in the event that we, or either of us, cannot be reached, we authorize the calling of a doctor and the providing of necessary medical services in the event the Participant is injured or becomes ill. We authorize any one or more of the following persons to make emergency medical care decisions on behalf of the Participant, if required by law or a health care provider: Sponsor-James River Church representative (JRC employee, board member, officer or volunteer)

We, the parents and/or guardians of Participant, understand that James River Church, and James River Charities LLC, (collectively "JRC") or any of their agents, employees, or volunteers, shall not be responsible for medical expenses incurred on the basis of this authorization. We hereby agree to hold harmless, defend and indemnify JRC, its parents, subsidiaries and affiliates, board members, officers, employees, agents and volunteers from all obligations, damages, losses, attorney's fees, defense costs, demands, investigations, actions, liabilities, claims, cross-actions, third-party actions, causes of action, of any kind or nature whatsoever, **including the negligence or gross negligence of JRC (**collectively "claims"), that may be asserted by anyone and that has any relation to the Participant. It is our express intention to defend, indemnify and hold harmless JRC from all claims arising out of, or resulting from, or in any manner relating to the treatment, medical or otherwise, of Participant.

We agree to notify JRC in the event of any health changes which would restrict the Participant's participation in any activities. We also understand that any JRC representative reserves the right to restrict the Participant from any activity for any reason.

Medical Provider Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____