Freedom Fellowship, Inc.

4373 Wade Hampton Blvd.
Taylors, S.C. 29687
(864) 631-1336 ♦ ♦ www.freedomfellowshipsc.com

LIMITED POWER OF ATTORNEY FOR MEDICAL EMERGENCIES

_____
Student's Full Name (please print)

In case of an emergency, I understand that every effort will be made to contact me immediately, should medical care be necessary for my child. Therefore, I hereby give an adult with Freedom Fellowship, Inc., and/or qualified medical personnel limited power of attorney to act on my behalf in securing and administering necessary first aid or emergency medical care and treatment for my child. I also release all sponsors, staff, counselors, and members of Freedom Fellowship, Inc. from any responsibility, liability, and medical payments in acting on my behalf in this regard. This form will remain in effect from January 1, 2018 to December 31, 2018, while my child is a participant in the Freedom Fellowship, Inc. Student Ministry. I understand that this form will be kept on file at the church and a copy is carried on all trips and outings. All information is confidential and will only be released to leaders in charge of my child and appropriate medical personnel.

_____
Parent / Legal Guardian Signature

CHILD INFORMATION (Please print.)

_____
Address

_____
Birthdate

_____
City / State / ZIP

_____
Social Security No.

_____
Home Phone

_____
E-mail Address

PARENT / LEGAL GUARDIAN INFORMATION (If child is a minor.)

Mother's Information

_____
Name

_____
Address (If different from above.)

_____
City / State / ZIP (If different from above.)

_____
Home Phone (If different from above.)

_____
Workplace

_____
Work Phone

_____
Mobile Phone

_____
Email Address

Father's Information

_____
Name

_____
Address (If different from above.)

_____
City / State / ZIP (If different from above.)

_____
Home Phone (If different from above.)

_____
Workplace

_____
Work Phone

_____
Mobile Phone

_____
Email Address

Emergency Contact & Phone Number
(For use only in the event that a parent / legal guardian cannot be contacted)

MEDICAL INSURANCE INFORMATION*

Is your child covered under any major medical insurance policy? ❑ YES ❑ NO

If "YES" Please fill out the following:

_____ Insurance Company

_____ Insurance Company Phone

_____ Policy / Group No.

_____ Policy Holder

* Any student participating in a Student Ministry event with Freedom Fellowship, Inc. will be covered by major medical insurance. Should the need arise for medical attention, the parent or guardian's insurance carrier will be the primary insurance provider. If the child is not covered by any other policy, then Freedom Fellowship, Inc.'s insurance policy will cover the child during the course of the event.

MEDICAL HISTORY

_____ Family Doctor

_____ Doctor's Phone

PRESCRIPTION MEDICINES

In the event that my child needs to receive prescription medicines, I give permission for my child to receive the following prescription medications, which will be administered only in accordance with the package's label.

PLEASE NOTE: An adult on the Ministry Team must be made aware of any prescription medicine that is to be taken during an outing. Prescription medications must be in their original packages along with specifics of any dosage changes, which differ from the label.

Please give a list of prescription medicines and dosages, which your student is currently taking:

_____

_____

_____

NON-PRESCRIPTIONS MEDICINES

I give permission for my child to receive "over-the-counter" medications on an "as needed" basis administered only as directed by the package's label.

Please check any medicines, which should **NOT** be administered to your child:

- ❑ **Acetaminophen** (Tylenol)
- ❑ **Ibuprofen** (Advil)
- ❑ **Triple Antibiotic Ointment** (Neosporin Ointment)
- ❑ **Diphenhydramine** (Benadryl)
- ❑ **Bismuth Subsalicylate** (Pepto-Bismol)
- ❑ **Loperamide** (Imodium AD)
- ❑ **Pseudoephedrine** (Sudafed)
- ❑ List any other medicines **NOT** to be given:

_____

_____

ONGOING CONDITIONS

Please check any ongoing conditions that your child may have which we need to be aware:

- ❑ Food allergies (specify):_____
- ❑ Drug allergies (specify): _____
- ❑ Environmental allergies (specify): _____
- ❑ Physical limitations (specify): _____
- ❑ Other:_____

PERMISSION SLIP

I hereby certify that _____ is my child or legal ward and resides with me. I give consent for him/her to participate in the student activities of Freedom Fellowship, Inc. I understand that my youth may be travelling by church van or bus, rental van or bus, or private vehicle driven by designated adults (over the age of 21) to said destination and return back to the church. I also understand that all reasonable care will be exercised for the wellbeing of my child. I hereby release and hold harmless all sponsors, staff, agents, counselors, and members of Freedom Fellowship, Inc. from any responsibility for the results of accident, injury, or death during our current year (see "Limited Power of Attorney For Medical Emergencies".) Should it be necessary for our (my) child to return home due to medical reasons, disciplinary action, or otherwise, the **undersigned shall assume all transportation costs**.

_____ (Parent Signature)

_____ (Date)