Burke Community Church
MEDICAL/MEDIA RELEASE FORM

Student's Name: ____ **Expiration Date: 9/30/19**

Date Form Completed: ______________________________Date of Birth: ___________________

Street Address: ____

City: _________________________________ State: ______________ Zip Code: ____________

Home Phone: ______________________________ Grade: ______ School: ___________________

Father's Name: ____________________________ Mother's Name: ________________________

Father's work phone: ________________________ Mother's work phone: ___________________

Father's cell phone: ____________________________ Mother's cell phone: ___________________

Father's email address: _______________________ Mother's email address: ___________________

Insurance Company: _____________________________ Policy #: _________________________

Group Name: ____________________________________ Group #: _________________________

Name of Primary Insured ____

Date of Birth of Primary Insured ____

PHYSICAL/MENTAL/BEHAVIORAL

Does your child have any physical, emotional, mental or behavioral concerns or limitations that our staff should be aware of? No Yes (please explain)

____

Has your child ever had or currently have any of the following (please explain):

- ◻ seizures
- ◻ asthma
- ◻ diabetes
- ◻ heart problem or heart disease
- ◻ memory lapse
- ◻ fainting
- ◻ other___________________
- ◻ other___________________

Date of last tetanus shot:____

MEDICATION

Does your child regularly take any medication? No Yes
If yes, please indicate dosage, frequency and any additional instructions.

____

PLEASE NOTE: Medication should be in its original prescription bottle package, which should have administration instructions and the child's name clearly indicated.

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ALLERGIES

Is your child allergic to:

□ bee stings □ straw
□ penicillin □ pollens
□ sulfa drugs □ other (foods, etc.) ____

Are any of these life-threatening allergies? No Yes (please specify)

____

____

MEDICAL RELEASE

I hereby authorize Burke Community Church and its officers, agents, volunteers and employees who supervise the activities with Burke Community Church (who are 21 years of age or older) to consent to medical care in the event that a medical or dental emergency occurs (hereinafter "Agent"). It is expressly understood that in order to be an Agent under this Release, the officer, agent, volunteer and/or employee of Burke Community Church must be 21 years of age or older.

The authority granted by this authorization includes the following:

A. To consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child;

B. To consent to or refuse or withdraw consent to any type of health care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, provided however, that such consent is made because the treating physician has determined the situation to be an emergency situation, and Agent has been unable to reach me by phone;

C. To employ and discharge health care providers (to the extent that this provision does not override paragraph B above);

D. To authorize my child's admission to or discharge (including transfer to another facility) from any hospital or other medical care facility. I further authorize Agent to receive physical custody of my child upon completion of any treatment;

E. Further, my Agent shall not be liable for the costs of health care pursuant to his authorization, based solely on that authorization. A determination that one or more powers granted under this instrument is invalid shall not affect the validity of any other powers granted herein. This authorization may be revoked by me at any time.

F. I specifically direct that my child receive health care that is medically appropriate under the circumstances as determined by my child's attending physician.

G. I specifically direct that the following health care not be provided to my child under the following circumstances (you may specify that certain health care not be provided under any circumstances): ____

____

____

Student's Name: ____ **Expiration Date: 9/30/19**

Medical Records & HIPAA Compliance. Regardless of the time of commencement of the other powers granted my Agent or any successor Agent appointed by this document, I authorize and instruct any physician, health care professional, health care provider, and medical care facility to provide to my Agent, or any successor Agent appointed by this document, information relating to my child's physical and dental condition and the diagnosis, prognosis, care and treatment thereof upon the request of my Agent or any successor Agent appointed by this document. It is my intent by this authorization for my designated Agent to be considered a personal representative under privacy regulations related to protected health information and for my Agent to be entitled to all health information in the same manner as if I personally were making the request. This authorization and request shall also be considered a consent to the release of such information in the same manner as if I were making the request. This authorization and request shall also be considered a consent to the release of such information under current laws, rules, and regulations as well as under future laws, rules, and regulations and amendments to such laws, rules, and regulations to include but not be limited to the express grant of authority to personal representatives as provided by Regulation Section 164.502(g) of Title 45 of the Code of Federal Regulations and the medical information privacy law and regulations generally referred to as HIPAA.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, and is given to provide authority and power on the part of the supervisor and his authorized designee, in the exercise his best judgment on what is advisable for my child's care, upon advice of such physician, dentist and surgeon.

Signature of Parent/Guardian:____ Date:_____________

Person to contact if parent/guardian cannot be reached: ____

Relationship: ____ Phone: __________________________

<u>MEDIA RELEASE FORM</u>

By completing this form, I give Burke Community Church permission to use my/my child's photograph, interview and or likeness thereof, on the Church's website and/or printed material to be distributed for public viewing.

I understand I will not receive any compensation from Burke Community Church and agree to hold Burke Community Church harmless from any future claims and/or liability that may arise from such usage.

Signature of Parent/Guardian:____ Date:_____________

Student's Name: ____ **Expiration Date: 9/30/19**

PERMISSION, REPRESENTATION, RELEASE,
ASSUMPTION OF RISK AND INDEMNITY AGREEMENT
FOR ACTIVITIES HELD AT BURKE COMMUNITY CHURCH
AND VARIOUS OTHER LOCATIONS
FOR THE YEAR ENDING SEPTEMBER 30, 2019

We are the parents or legal guardians of ______________________________, (our "**Child**"), a minor under eighteen (18) years of age, for whom we give permission to come on the property known as 9900 Old Keene Mill Rd., in Burke, Virginia (the "**Premises**"), and various other locations, with others, and to participate in activities to be held at Burke Community Church, and various other locations, which event is being sponsored by Burke Community Church, (hereinafter collectively called "**BCC**"), and their respective members, owner-operators, employees, independent contractors and agents (the "**Event"**) beginning July 1, 2018 and ending September 30, 2019.

We expressly agree, on behalf of our Child and ourselves, to assume all of the risks on and off the Premises, connected with our Child's participation in the Event.

As a further inducement to BCC, we agree to hold harmless and fully indemnify BCC, its respective officers, directors, members, owner-operators, employees, agents, officials and any other persons acting on behalf of BCC and the owner(s) of the Premises, from any and all liability, claims, actions, causes of action or demands, or suits of any kind, nature, character and description (collectively the "**Claims**"), including attorneys' fees and costs, made or claimed by or on behalf of our Child for any injury, damage, loss, or other matter arising out of or related to our Child participating in the Event.

And we further waive any and all Claims that we or our Child may now have or which may arise in the future, and further covenant not to sue the above named organizations or persons, including landowners, for any injury or damages resulting from the subjects of this document. This Agreement shall bind the parties hereto, their successors and assigns and shall remain in effect for so long as any of the foregoing activities occur. The validity, enforceability and interpretation of this Agreement shall be determined and governed solely by the laws of the Commonwealth of Virginia.

The undersigned hereby declares that the terms of this Agreement have been completely read and are fully understood and voluntarily accepted. The undersigned represents that they are the sole parents and guardians of the Child and have full authority to enter into this Agreement on behalf of the Child.

Signature of Parent/Guardian:____ Date:_____________

Printed Name of Parent/Guardian:____

Signature of Parent/Guardian:____ Date:_____________

Printed Name of Parent/Guardian:____