EMERGENCY PERMISSION & HEALTH FORM

(FOR STUDENT AND ADULT ATTENDEES)

FOR YOUTH PARTICPANTS:

I hereby give my permission for River of Life counselors to seek medical help for my child, _____, in any situation they deem merits such help. I also give permission for medical and emergency response personnel, in my absence, to administer any treatment, including surgery, that they deem to be necessary during the time my child is en route to and from, and participating in, the River of Life event to be held at Forest Hills United Methodist Church on July 11-15, 2018.

My child has my permission to be assigned to a work team that will paint, roof, build and repair porches, and do other home repairs and improvements. (Any type of work I have not approved has already been noted on my child's Registration Form.) I will not hold River of Life, its Directors, Coordinators, Host Church, Participating Churches, or Counselors responsible for any injuries incurred by my child. I will not allow my child to drive during the event.

Signature of Parent/Guardian_____Date_____

FOR ADULT PARTICPANTS:

I herby give my permission for River of Life counselors to seek medical help for me, _____ if there is any situation they deem merits such help and I am unable to participate in that decision. I also give permission, if necessary, for medical and emergency response personnel, to administer any treatment, including surgery, they deem to be necessary during the time I am en route to and from and participating in, the River of Life event to be held at Forest Hills United Methodist Church on July 13 – 17, 2016.

Signature of Adult Participant _____Date_____

FOR ALL PARTICIPANTS:

1. Is the participant named above covered under hospitalization insurance?
   _____ yes _____no If no, skip to line 5.

2. Dose the participant have an insurance card? _____ yes _____no
   IF YES, ATTACH A COPY OF THE CARD UNDER WHICH THE PARTICIPANT IS COVERED
   NOT CONSIDERED REGISTERED UNTIL THIS CARD IS SUBMITTED

3. Name of Insurance Company _____
   Policy Number_____

4. Name of Person in which Insurance is carried: _____

5. Family Physician_____
   Doctor's Office Telephone_____
   Participant's Blood Type _____

6. Primary person to contact in emergency: _____
   Contact Number: _____
   Secondary person to contact in emergency: _____
   Contact Number: _____

7. Please list any allergies to medications, foods, insect stings, etc. _____
   _____

8. Does your child take medications routinely? _____yes _____ no If yes, list name of medication, strength, and schedule: _____

9. Are there any medical conditions that are relevant to the participant's work and involvement at ROL? If yes, explain.
   _____