LIFE Fellowship Frederick

451 Oak Street Suite 100 Frederick, CO 80530

Permission for Church Sponsored Activity and Consent to Medical Treatment

Please complete both top and bottom of form

(Name of Participant)________________________________ has the opportunity to participate in an activity at and away from church premises. If you approve the following arrangement, please sign at the bottom of this section and return to the faculty sponsor.

NATURE OF ACTIVITY: "Youth in the Community" to include all work, activities, recreation, and transportation.
DATE June 4th-9th, 2018 ACTIVITY SPONSOR: LIFE Fellowship of Frederick

I acknowledge that participation in the activity described above involves risk to the Participant and may result in various types of injury including, but not limited to, the following: sickness, bodily injury, death, emotional injury, personal injury, property damage, and financial damage. In consideration for the opportunity to participate in the activity described above (the "Activity"), the Participant acknowledges and accepts the risks of injury associated with participation in and transportation to and from the Activity. The Participant accepts personal financial responsibility for any injury or other loss sustained during the Activity or during transportation to and from the activity, as well as for any medical treatment rendered to the Participant that is authorized by the Sponsor or its agents, employees, volunteers, or any other representatives (collectively referred to hereinafter as the "Activity Sponsor"). Further, the Participant (or parent/guardian) releases and promises to indemnify, defend, and hold harmless the Activity Sponsor for any injury arising directly or indirectly out of the described Activity or transportation to and from the Activity, whether such injury arises out of the negligence of the Activity Sponsor, the Participant, or otherwise.

Date: __________________ Signature of Parent/Guardian __________________________________

IMPORTANT MEDICAL INFORMATION THE SUPERVISOR SHOULD KNOW:

EMERGENCY TELEPHONE NUMBERS: ____

(Please complete the form below)

AUTHORIZATION TO TREAT A MINOR

I (We), the undersigned parent, parents or legal guardian of ____________________, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by an is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Colorado Department of Public Health. It is understood that effort shall be made to contact the undersigned prior to rending treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

INSURANCE PROVIDER: __________________ GROUP#:__________________ MEMBER ID #: __________________

Date:___________ Signature of ____
Father and/or Mother, or Guardian

Allergies to Drugs or Foods ____

Date of last Tetanus Booster ____