CREATION MUSEUM OVERNIGHT STAY

Permission, Liability Release and Medical Authorization Form

Creation Museum Overnight Stay
DATE _____
CHILD'S NAME_____ AGE_____
PARENT/GUARDIAN NAME_____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
PHONE (_____) _____
ALTERNATE EMERGENCY PHONE (_____) _____

Consent to attend

I hereby authorize _____ (my child or ward) to participate in an overnight stay and in all activities involved with the stay at the Answers in Genesis Creation Museum on _____, 20___. I hereby release, and agree to indemnify and hold harmless, Answers in Genesis, and all directors, officers, employees, agents and representatives of Answers in Genesis from and against any and all liabilities, loss, or damage to persons or property which may occur in connection with the program, to the fullest extent permitted by law. I agree to assume all risks associated with my child's participation in the program.

Parent/ Guardian Signature_____ Date_____

Permission to render emergency medical care

I _____ , the _____ (father, mother, guardian) of _____ (child's name), the minor participating in the overnight stay, hereby authorize Answers in Genesis public safety personnel, and other employees, volunteers, agents, and representatives of Answers in Genesis to render emergency medical care to my child within their scope of training, and to act on my behalf to consent to any medical, hospital or emergency care or treatment deemed to be necessary or advisable for the child upon the advice of any licensed physicians, dentists, nurses, or emergency medical personnel. I also give consent for my child to be transported to an emergency medical care center if the need arises. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization. I agree to indemnify and hold harmless Answers in Genesis, its employees, agents and representatives, from any and all liability in connection with such medical treatment.

Parent/ Guardian Signature_____ Date_____

Medical Information

Family Physician's name_____ Business Phone (___)_____

CHILD'S MEDICAL HISTORY
Is child in good health? _____ List Allergies: _____
_____Date of last tetanus shot: _____ ____
List any physical impairments (such as Heart, Epilepsy, Diabetes, etc.):
_____
Specify any medication that must be administered:
_____
Other special instructions _____
_____

Health Insurance company name:_____

Policy Number _____ Telephone _____