Medical Release Agreement

I/we the undersigned, as the parents having legal custody, or the legal guardians of the above named participant, a minor, have given our consent for him/her to attend a camp or conference operated by BigStuf Camps, or are of legal consenting age myself. In the event that I/he/she is injured while attending the camp or conference and requires the attention of medical personnel, I/we consent to any reasonable medical treatment as deemed necessary by a qualified medical professional. In the event treatment is called for, which a medical professional and/or hospital personnel refuses to administer without my/our consent, I/we hereby authorize an adult leader of our group or a member of the BigStuf Ministries staff to give such consent for us if I/we cannot be reached by telephone at one of the numbers listed below, or because of an emergency, there is not time or opportunity to make a telephone call. In the event it becomes necessary for that person to give consent for us, I/we agree to release and hold them harmless of any claims, demands or suits for damages arising from the giving of such consent so long as the treatment is administered by or under the supervision of a medical professional. I/we also acknowledge that I/we will be ultimately responsible for the cost of any medical care should the cost of that care not be reimbursed by the health insurance carrier. Further, I/we affirm that the health insurance information provided below is accurate at this date and will, to the best of my/our knowledge, still be in force at the time of the camp or conference.

Emergency Contact Information (please provide two)

Name: _____ Name: _____

Relationship to Participant: _____ Relationship to Participant: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

In compliance with HIPAA privacy laws, the section below will be detached and disposed of after completion of camp.

Medical Information*

Participant Name: _____

Gender: Female Male

Date of Birth: _____/_____/_____

Home Address:

_____

Phone: _____

Date of Last Tetanus Shot: _____

Known Allergies:

_____

Current Medications or Health Conditions:

_____

_____

____

To be used only to determine course of treatment in the event of a medical situation.

Insurance Information*

Name of Health Insurance Company:

_____

Health Insurance Group Number: _____ Health Insurance Policy Number:_____

Address of Health Insurance Company:

_____

Phone of Health Insurance Company:

_____

Name of Policy Holder:

_____

Policy Holder's Phone Number:

_____

Check the following box if the participant does not have insurance*:

**Participants without health insurance are still able to attend, understanding the risks and personal liability to any and all medical payments.*