



Calvary Chapel St. Pete Medical Release and Liability Form

Event Title: TILT Weekend 2010 – “Standing firm in a world made of Jell-O”

I (We) acknowledge that my teen’s participation in the activities of Calvary Chapel St. Pete is voluntary and may require involvement in traveling and physical exertion. **My teen has permission to attend the Teens In Leadership (TILT) Weekend Training Retreat at Lakewood Retreat in Brooksville, Florida on March 26-28, 2010.** In consideration of the activity or event my minor teen is participating in, I hereby represent and warrant that my minor teen is fully, physically, and medically capable of partaking in same and that accidents, injuries, death and/or damages caused by other individuals may occur. It is my consent on behalf of my minor teen to acknowledge and assume such possibility and I/we hereby release and forever discharge Calvary Chapel St. Pete, and its affiliates (Pathways Community Church, North Side Baptist Church, Living Hope Community Church), including their officers, agents, employees, and representatives from all claims, damages, injuries, medical treatment expenses, medical transportation expenses and causes of action that may arise from the event or activity.

I (We), the parent(s) or legal guardian, do hereby authorize any one or more members of Calvary Chapel St. Pete, in whose care the minor has been entrusted, as agents for myself in my absence or incapacitation to consent to any x-ray examination and anesthetic, medical, surgical, or dental diagnosis or treatment and medical care which is deemed advisable by and is to be rendered under the general or special supervision of any physician, physician’s assistant, licensed practical nurse, EMT or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital or out patient clinic, whether or not such diagnosis or treatment is rendered at the office of said physician or medical staff or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and/or dental services rendered, including emergency medical transportation, to the aforementioned teen pursuant to this authorization.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his or her best judgement may deem advisable.

I hereby authorize any hospital or physician which has provided treatment to the above-named minor to surrender physical custody of such minor to the above-named agents upon the completion of treatment.

Copies of this form, duly executed, should be in the possession of the named minor; at least one adult named in the document and present at the event; and the parent or guardian executing the Medical Authorization. A duly executed copy of this form shall have the same force and effect as the original.

Parent(s)/Legal Guardian Signature _____ Date _____

Identification # _____ Type _____ State _____

**STATE OF FLORIDA
COUNTY OF PINELLAS**

BE IT KNOWN, that on the ____ day of _____, _____, before me, the undersigned notary in and for the State of Florida, duly commissioned and sworn, dwelling in the county of Pinellas, personally came and appeared _____, to me () personally known or () who produced valid identification, and being the same person described in and who executed and acknowledged the within medical authorization and release to be his/her act and deed.

Notary Signature _____ Notary Stamp: _____

OR

Signature of Calvary Chapel Staff member _____ Printed name of Staff member _____ Date _____



Health Information Form

Please Print in Ink

Participate Name _____ **Age** _____ **Grade** _____

Participate Email: _____ **Birthday** ____/____/____

Parent/ Guardian _____ **Email** _____

Phone (H) _____ **Phone(W)** _____ **Phone(C)** _____

Address _____

City _____ **State** _____ **Zip** _____

Second Parent /or Alternate Emergency Contact _____

Phone (H) _____ **Phone (W)** _____ **Phone (C)** _____

Medical Insurance Carrier _____

Policy # _____ Group # _____

Carrier Address _____

Name of insured person _____

Insured person's place of employment _____

Name of Family Physician _____ Phone _____

Name of Dentist/Orthodontist _____ Phone _____

Health History (Check/Give Approximate Dates) Allergies (Dates Not Needed)

____ Frequent Ear Infections ____ Diabetes ____ Bleeding Disorders ____ Hay Fever ____ Penicillin ____ Heart Defect/Disease
____ Asthma ____ Mononucleosis ____ Seizures ____ ADD/ADHD ____ Downs Syndrome ____ Other (specify)
____ Tourette's Syndrome ____ Mumps ____ Chicken Pox ____ Measles
____ Drug Allergies (please specify _____)

____ Allergies (Other – non food related) (please specify _____)

Chronic/recurring illness/medical conditions including mental illness (depression, anxiety, etc.)

Dietary Restrictions/ Food Allergies _____

Current Medications (list all prescriptions, OTC and herbal)

Attach Separately: Medication name / Dosage / Reason for Taking

Blood Type (if known) _____ All immunizations current? Yes ____ No ____ Date Last Tetanus _____

Describe your teen's swimming ability: Non Swimmer ____ Beg ____ Inter ____ Advanced ____

Any other information you feel the leaders should know in advance about your teen?

Initial _____ **I give my permission to the staff to administer Tylenol/Acetaminophen, Ibuprofen, Benadryl, Diphenhydramine or over the counter antacids, as needed.**

Initial _____ **My teen may sleep on a top bunk.**

For your information, these are the rules of conduct expected from each teen:

- Respect one another, staff and adult leaders
- No alcohol, dugs, tobacco permitted
- No lighter permitted
- No fighting, weapons, fireworks, explosives
- Respect property
- No offensive or immodest clothing
- No boys in girls' sleeping quarters, visa versa
- Participation is expected

Parent(s)/Guardian Signature _____ **Date** _____

Teen's Signature _____ **Date** _____