

Grace Lutheran Church and School Event & Liability Form
PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

Activity Consent

Participant's Name: _____

Birth Date: _____ Gender (circle one): M or F

Parent/Guardian's Name: _____

Home address: _____

Home phone: _____ Cell 1 _____ Cell 2 _____

I _____, request GLCS allow my/our

son/daughter _____ (Child's Name) to participate in Grace Lutheran Church & School (GLCS) youth activities at the church site and those that require transportation to a location away from the church site. This activity will take place under the guidance and direction of employees and/or volunteers from Lutheran Church-Missouri Synod (LCMS), Grace Lutheran Church & School (GLCS), 856 W. Newgrove St., Lancaster CA.

A brief description of the activity follows:

Type of Event: _____

Departure Date _____ Return Date _____

Departure Time _____ Return Time _____

Location: _____

Mode of transportation to/from event: _____

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant"). I understand and agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, that in consideration of the participation of my child in youth ministry events and activities to release, discharge, hold harmless and defend GLCS, LCMS, their pastors, volunteer or paid staff, officers, council, members and agents, and chaperones, or representatives associated with this activity from any act or omission resulting in any property damage, personal injury and bodily injury, including death, to my child, which is caused or claimed to be caused, in whole or in part, by their negligent acts or omissions of the parties, including reasonable attorney's fees and expenses arising in connection therewith.

Signature: _____ Date: _____

Signature: _____ Date: _____

(form includes reverse side medical consent & liability waiver—signatures are valid for both sides)

PARENTAL/GUARDIAN MEDICAL CONSENT FORM AND LIABILITY WAIVER

Medical Matters

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. (*Of the following statements pertaining to medical matters, check only those that are applicable.*)

Participant's Name: _____

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the phone numbers on the reverse side, contact:

Your Name: _____ Relationship _____

Home Phone: _____ Cell 1 _____ Cell 2 _____

Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy # _____

Other Medical Treatment: In the event it comes to the attention of GLCS, LCMS, their pastors, volunteers or paid staff, officers, council, members and agents, and chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, or a serious injury, I want to be called.

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are:

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life threatening and emergency treatment is required.

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Specific Medical Information: GLCS, LCMS, their pastors, volunteers or paid staff, officers, council, members and agents, and chaperones, or representatives associated with the activity will take reasonable care to see that the following information will be held in confidence. Allergic reactions (medications, foods, plants, insects, etc.):

 Medically prescribed diet? _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

Are there any physical limitations? _____

You should be aware of these special medical conditions of my child:
