



THE LUTHERAN CHURCH – MISSOURI SYNOD
OFFICE OF NATIONAL MISSION, YOUTH MINISTRY
MEDICAL CONSENT AND LIABILITY RELEASE FORM

This form must be completed and carried by all participants and a copy given to group leader.
This form must be signed by parent/guardian of participants under 21.

Please type or print in ink.

PARTICIPANT NAME: (Last) _____ (First) _____

BIRTH DATE: ____ / ____ / ____ MALE: ____ FEMALE: ____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: () _____ DAY PHONE: () _____

CUSTODIAL PARENT/GUARDIAN: _____

HOME PHONE: () _____ DAY PHONE: () _____

HOME ADDRESS (IF DIFFERENT): _____

HEALTH PLAN CARRIER: _____

NAME OF INSURED: _____

RELATIONSHIP TO PARTICIPANT: _____

POLICYHOLDER/INSURANCE ID#: _____

FAMILY DOCTOR: _____

OFFICE PHONE: () _____ MEDICAL EXCHANGE: () _____

FAMILY DENTIST: _____ OFFICE PHONE: () _____

SECOND PARENT OR EMERGENCY CONTACT: _____

RELATIONSHIP TO PARTICIPANT: _____

HOME PHONE: () _____ DAY PHONE: () _____

Please specify if any health insurance pre-certification, notification, or other requirements exist for the health participant.

Please copy front and back of participant's/cardholder's insurance card in the space below:

Medical Card Copy Front

Medical Card Copy Back

Consent and Release Form (continued)

I understand that the 2019 LCMS Youth Gathering for which this Medical Consent and Liability and Activity Release Form is being given is described as follows:

A national event of The Lutheran Church – Missouri Synod for youth and their adult leaders held in Minneapolis, MN on July 11-15, 2019. This event may include group training meetings and discussions, service projects, recreational activities, fellowship and learning activities.

I hereby consent to participation of myself (or of my child) in the above-described event. I have read the informational materials regarding the planned activities. I am aware that in addition to activities such as Bible study, worship, sight-seeing, using public transportation, and meal functions, the participant also may choose to participate in various recreational sports activities or service projects that may involve additional risks, such as: jumping, running or other physical movements during sports activities; or using tools or ladders or other equipment while taking part in community service projects.

I understand that I have a duty to provide primary accident and medical insurance for myself (or for my child) and I declare that I am (or my child is) covered by primary accident and medical insurance.

FURTHERMORE, I DO HEREBY EXPRESSLY STIPULATE, AND AGREE TO INDEMNIFY AND HOLD FOREVER HARMLESS THE LUTHERAN CHURCH – MISSOURI SYNOD, OFFICE OF NATIONAL MISSION – YOUTH MINISTRY, US BANK STADIUM, MINNEAPOLIS CONVENTION CENTER AND _____ (NAME OF DISTRICT/HOME CONGREGATION), ITS AGENTS AND SERVANTS, SUCCESSORS AND ASSIGNS, DIRECTORS, TRUSTEES, OFFICERS, EMPLOYEES, AND OTHER REPRESENTATIVES AGAINST LOSS FROM ANY AND ALL PRESENT OR FUTURE CLAIMS, DEMANDS OR ACTIONS IN LAW OR IN EQUITY THAT MAY HEREAFTER BE MADE OR BROUGHT BY ME OR MY CHILD, BY ANYONE ON BEHALF OF ME OR MY CHILD, OR BY ANYONE ELSE ON THEIR OWN BEHALF FOR DAMAGES OR ANY OTHER LEGAL OR EQUITABLE REMEDY ON ACCOUNT OF ANY INJURY, ILLNESS, PHYSICAL CONDITION, INCONVENIENCE OR LOSS SUSTAINED BY ME OR MY CHILD DURING THE EVENT OR TRAVEL TO AND FROM THE SAME.

I have read this release and hold harmless agreement and understand the terms used in it and their legal significance. This waiver and release is freely and voluntarily given with the understanding that right to legal recourse against THE LUTHERAN CHURCH – MISSOURI SYNOD, OFFICE OF NATIONAL MISSION – YOUTH MINISTRY, US BANK STADIUM, MINNEAPOLIS CONVENTION CENTER AND _____ (NAME OF DISTRICT/HOME CONGREGATION) and the officers, directors, employees, volunteers, and agents of each of them is knowingly given up in return for allowing my (or my minor child's) participation in the activity. My signature on this document is intended to bind not only myself but also my successors, heirs, representatives, administrators, and assigns.

FOR PARTICIPANTS AGE 21 AND OVER:

Participant Signature

Date

Witness

FOR PARTICIPANTS UNDER AGE 21:

Parent/Guardian of Participant
(if Participant is under 21)

Date

Witness

AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE

This form must be completed and signed by parent/guardian of participants under 21.

A parent/guardian signature is needed for participant to take part in activities.

(I)(We), the undersigned parent(s) and/or natural guardians(s) of _____, a minor, do hereby authorize my child’s Adult Leader (and/or any other adult appointed or designated by him/her) or LCMS Youth Ministry Staff to (i) consent to medical, surgical and dental care for such minor child, (ii) consent to any diagnostic tests, medical, surgical or dental procedure or treatment as may be considered therapeutically necessary by the physician, surgeon, dentist or other health care personnel providing care for such minor child, and (iii) on (my)(our) behalf, to (a) employ physicians, surgeons, dentists, nurses, and other health care personnel as may be deemed necessary for such minor child, (b) admit such minor child to any hospital, clinic, emergency room, laboratory or other health care or diagnostic facility for examination, treatment, surgery or care, and (c) sign all necessary consents and authorizations. It is understood that this authorization is given in advance of the occurrence of any condition or situation which would necessitate any such medical, surgical, or dental care being required but is given to provide authority to obtain such care if it should be required. I fully understand the consequences of the foregoing statements and sign this AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE knowingly, freely and willingly.

This authorization shall continue for such time as my child is participating in the 2019 LCMS Youth Gathering and during travel to and from the event.

Parent/Legal Guardian Date Parent/Legal Guardian Date

If over 21, complete this portion of this form.

I authorize my fellow Adult Leader or LCMS Youth Ministry Staff to (i) consent to medical, surgical and dental care for me, (ii) consent to any diagnostic tests, medical, surgical or dental procedure or treatment as may be considered therapeutically necessary by the physician, surgeon, dentist or other health care personnel providing care for me, and (iii) on my behalf, to (a) employ physicians, surgeons, dentists, nurses, and other health care personnel as may be deemed necessary for me, (b) admit me to any hospital, clinic, emergency room, laboratory or other health care or diagnostic facility for examination, treatment, surgery or care, and (c) sign all necessary consents and authorizations. It is understood that this authorization is given in advance of the occurrence of any condition or situation which would necessitate any such medical, surgical, or dental care being required but is given to provide authority to obtain such care if it should be required. I fully understand the consequences of the foregoing statements and sign this AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE knowingly, freely and willingly.

This authorization shall continue for such time as I am participating in the 2019 LCMS Youth Gathering and during travel to and from the event.

Participant Signature Date



EMERGENCY MEDICAL INFORMATION FORM

Please complete so that health providers can be aware of your personal health needs.
This form must be completed and carried by all participants.

Name of Participant: _____

Does participant have: (if "yes", explain)

___ Yes ___ No ALLERGIES? _____
___ Yes ___ No HEART CONDITION? _____
___ Yes ___ No OTHER? _____

Is participant subject to: (If "Yes", explain)

___ Yes ___ No HEADACHES? _____
___ Yes ___ No SEIZURES? _____
___ Yes ___ No MOTION SICKNESS? _____
___ Yes ___ No FAINTING? _____
___ Yes ___ No SLEEP WALKING? _____
___ Yes ___ No UPSET STOMACH? _____
___ Yes ___ No OTHER? _____

Does participant have reaction to: (If "Yes", explain)

___ Yes ___ No BEE STING? _____
___ Yes ___ No PENICILLIN? _____
___ Yes ___ No OTHER DRUGS? _____
___ Yes ___ No POISON IVY, OAK, SUMAC? _____
___ Yes ___ No OTHER? _____
___ Yes ___ No Has the participant had any serious illness or surgery within the past ten years?
Please list: _____

___ Yes ___ No Does the participant have any condition that would prevent him/her from participating in any
activities? Please list: _____

___ Yes ___ No Does the participant take any prescription medication? Please list: _____

___ Yes ___ No Are any drugs ineffective in treatment? _____

___ Yes ___ No Is the participant diabetic? Medication? _____

___ Yes ___ No Does the participant have any sight or hearing impairment? _____

___ Yes ___ No Does the participant wear contact lenses? _____

___ Yes ___ No Does the participant wear hearing aids? _____

Blood type: _____ Date of last Tetanus shot? _____

A current tetanus shot is required. After 7 years another tetanus shot is recommended.

Please indicate ANYTHING else that the leaders should know to help avoid or deal with any medical situation that might arise:

