Missio Dei Fellowship Medical and Liability Release Form

Youth Participant's name(s): _____, _____,
(include date of birth)
_____, _____

Address: _____ City: _____

State: _____ Zip:_____ Phone: (____) _____

Parent/Guardian: Please carefully read and completely fill in the following:

I give permission for my above-named child (or children) to participate in the 2013 Corn Maze event. I realize and acknowledge that participation in this trip includes some risks and possible dangers. I am well aware that participating in the Corn Maze event exposes my child to such risks as accidents, injury from outdoor activities, illness, and other possible dangers. I release the following from any liability in the event of an accident or injury en route to, during and/or returning from this activity: Missio Dei Fellowship, all staff persons connected within, and all adult leaders and chaperones.

In the event of an emergency, I understand that every effort will be made to contact me. In the event that neither I, nor the emergency contact person listed below, can be reached, I hereby give permission for adult leaders/chaperones to act in my behalf in seeking Basic First Aid or immediate Emergency Medical Treatment for my child at the nearest medical facility, in the event that such treatment is deemed necessary. I give permission to those administering emergency treatment to do so, using those measures deemed necessary. I understand that I will be notified, as soon as possible, about any medical concern. I absolve Missio De Fellowship and adult leaders/chaperones from liability in acting on my behalf in this regard.

I understand that I and/or my insurance company are responsible for medical expenses incurred. I agree to notify the leaders of the 2013 Corn Maze event, in writing, of any health information that would restrict my child's participation in this activity.

Signature of Parent/Guardian: _____ **Date:** _____

Home Phone: (___)_____ **Work:** (___)_____ **Cell:** (___)_____

Family Physician: _____ **Physician Phone:** (___)_____

Additional comments regarding current medications (reason, name, and dosage), medical history, mental health information, any allergies, reactions to medications, special diets, etc., which may be needed in any treatment:

_____
_____
_____

Medical Insurance Provider Name: _____ **Policy #:** _____
Policy Holder: _____ Group Number (if applicable): _____
Insurance Company Address: _____

Emergency Contact: (Relative, Neighbor, Friend) in case parents cannot be reached during an emergency
Name: _____ Home Phone: (____)_____
Address:_____ Work Phone: (____)_____
City: _____ State:_____ Zip:_____ Cell Phone: (____) _____

Parent's Attending:

_____ _____

_____ _____