

INDIANA DISTRICT YOUTH GATHERING
(All participants, youth and adult, must fill out this page!)

AUTHORIZATION OF MEDICAL/DENTAL TREATMENT OF MINOR

I/We, the undersigned parent(s)/guardian(s) of _____, a minor, do hereby authorize my child's group leader, youth counselor, or agent of the Indiana District Youth Gathering to:

- consent to medical, surgical, or dental care for such minor child
- 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,
- on my/our behalf to employ physicians, surgeons, dentists, nurses, and other health care personnel as may be deemed necessary for such minor child,
- 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
- sign all necessary consents and authorizations.

I understand that an attempt will be made to notify the parent(s)/guardian(s) first. If parent(s)/guardian(s) are not available, however, the above authorizations will be in effect.

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 it is given to provide authority to obtain such care if it should be required.

EMERGENCY CONTACT NAME: _____

RELATION TO CHILD: _____ PHONE: _____

FAMILY DOCTOR: _____ PHONE: _____

INSURANCE ID/MEDICAL EXCHANGE #: _____

FAMILY DENTIST: _____ PHONE: _____

I fully understand the consequences of the foregoing statements and sign this AUTHORIZATION FOR MEDICAL/DENTAL TREATMENT OF MINOR knowingly, freely, and willingly. (At least one signature must appear below or your child will not be permitted to attend.)

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

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CONSENT AND LIABILITY WAIVER

Each participant in the Indiana District Youth Gathering must fill in all and sign all appropriate spaces on this *Consent and Liability Waiver*, the *Emergency Medical Information Form*, and the *Authorization for Medical/Dental Treatment of Minor*. A parent/guardian of each participant under 21 must also sign in the appropriate spaces. The completed forms should be copied four times with one copy each to the driver, the main leader, the Gathering leadership, and the individual. Please type or print in ink!

PARTICIPANT NAME: _____

SOCIAL SECURITY NUMBER: _____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____

PARENT/GUARDIAN NAME: _____

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

HEALTH PLAN CARRIER: _____

POLICY HOLDER'S NAME: _____

POLICY NUMBER: _____

Do any pre-certification, notification, or other requirements exist with respect to the health insurance of the participant? If "yes", please specify!

Registrants will also be covered by a limited accident and medical insurance policy that provides reimbursement on an excess basis over each participant's own primary insurance policy. Registrants need to carry their own insurance as indicated above.

(over)

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CONSENT AND LIABILITY WAIVER *(continued)*

I give permission for my child to attend and fully participate in this year's Indiana District Youth Gathering. ***This permission also includes the rights to use my child's picture on the Gathering webpage or in any publicity materials.***

I release and forever discharge the *Indiana District Board of Youth Ministry (ID-BYM)*, the *Indiana District of the Lutheran Church-Missouri Synod (ID-LCMS)*, the *Lutheran Church-Missouri Synod (LCMS)*, and all churches and organizations involved; their agents and servants, successors and assigns, directors, trustees, officers, employees, and other representatives from any and all claims, damages, and causes of actions either at law or in equity which I may have as a result of my (or my child's) participation in, attendance at, and travel to and from the Gathering.

Furthermore, I do hereby expressly stipulate and agree to indemnify and hold forever harmless the *ID-BYM, ID-LCMS, LCMS*, and all churches and organizations involved; their agents and servants, successors and assigns, directors, trustees, officers, employees, and other representatives against loss from any and all present and future claims, damages, and causes of actions either at law or in equity that may hereafter be made or brought by me (or my child) during the Gathering, or travel to and from the Gathering.

By acceptance of participation in the Gathering, the undersigned agrees to the foregoing and also agrees that the *ID-BYM, ID-LCMS, LCMS*, and all churches and organizations involved; their employees and other representatives shall not be liable for loss, damage, injury, or inconvenience caused by or resulting from the malfunction of transportation equipment, strikes, acts of war or insurrection, fire, delays, theft, itinerary/schedule changes, or cancellations.

I/we have read the informational materials for this particular Gathering and understand and am/are aware of the risks involved in any planned activities.

If any conduct warrants exclusion from participation in the Gathering, I assume all responsibility for disciplinary action and/or picking up my child upon being notified by the adult supervisor in charge. Should it be necessary for the participant to return home due to medical reasons, disciplinary action, or otherwise, I hereby assume all transportation costs.

I/we, the undersigned, hereby acknowledge that I/we have read the foregoing, understand its contents, and have signed the same as my/our own free act and deed.

Participant signature Date Witness signature

Parent/Guardian signature Date Witness signature

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Emergency Medical Information

Does the participant have/subject to/reaction to: *(If "yes", please explain!)*

YES	NO	
___	___	Allergies? _____
___	___	Heart Condition? _____
___	___	Headaches? _____
___	___	Seizures? _____
___	___	Motion Sickness? _____
___	___	Fainting? _____
___	___	Sleep Walking? _____
___	___	Upset Stomach? _____
___	___	Bee Stings? _____
___	___	Penicillin? _____
___	___	Other drugs? _____
___	___	Poison Ivy, Oak, Sumac? _____
___	___	Any serious illness or surgery in the last ten years? _____
___	___	Any conditions which would limit participation? _____
___	___	Are any drugs ineffective for treatment? _____
___	___	Does participant have sight or hearing impairment? _____
___	___	Does participant wear contact lenses? _____
___	___	Is participant diabetic? _____

Date of last tetanus shot: _____

Please indicate anything else that leaders should know about the participant to help avoid or deal with any situation that might arise.
