

# FOURSQUARE EVENTS - PARENTAL CONSENT AND RELEASE FORM

*Information in this document is protected by HIPAA privacy laws and should be handled accordingly*

Each signed form is only good for travel during and attendance at a specific camp. A new form must be completed for each event.

<b>Event name:</b> _____	<b>Event Code:</b> _____	<b>District:</b> _____	<b>Date:</b> _____
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**Note to Parent/Guardian:** The Foursquare Church wants your child's experience at this event to be a safe and healthy one. However, in the event of an accident or illness, it is important that we have your child's current and past medical history and medical insurance information.

Child's Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender:  Male  Female

Parent/Legal Guardian Name: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If not available in an emergency, notify: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## ACCIDENT COVERAGE:

I understand that my personal insurance will be primary coverage for any accidents and that Foursquare's Insurance, which only covers medical expenses, is secondary up to a maximum of \$50,000, and does not cover illness. I also understand that if I have questions, I must contact ICFG Insurance at (213) 989-4400.

My Insurance Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Company Address/Web Address: \_\_\_\_\_

Not currently insured - ICFG reserves the right to subrogation if it is later determined that personal medical insurance was in place.

The child is currently under the care of a physician for the following condition(s): \_\_\_\_\_

Chronic or recurring illness or medical condition (including behavioral conditions): \_\_\_\_\_

Operations or serious injuries (including dates): \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion or concussion: \_\_\_\_\_

List any activities from which the applicant should be excluded: \_\_\_\_\_

List any medication/treatment to be administered during the event (specify dosages and intervals/times): \_\_\_\_\_

Family Physician or Medical Group: \_\_\_\_\_ Phone: \_\_\_\_\_

## ALLERGIES AND DIETARY RESTRICTIONS (List any food, drug, plant, insect or other allergies)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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IMMUNIZATIONS	HEALTH HISTORY
<input type="checkbox"/> Applicant has <b>NOT</b> been immunized for: <input type="checkbox"/> medical <input type="checkbox"/> personal <input type="checkbox"/> religious reasons <b>OR</b> <input type="checkbox"/> Check and date any immunizations the applicant has received:	Check the box next to any medical conditions experienced (past or present) by the applicant:
<input type="checkbox"/> DTaP (Diphtheria, Tetanus, & Pertussis)      Date: _____ <input type="checkbox"/> TD (Tetanus & Diphtheria)                              Date: _____ <input type="checkbox"/> MMR (Measles, Mumps & Rubella)                      Date: _____ <input type="checkbox"/> Polio (OPV or IPV)    Date: _____ <input type="checkbox"/> Hepatitis B    Date: _____ <input type="checkbox"/> Varicella (Chicken Pox)                                      Date: _____ <input type="checkbox"/> HIB (Haemophilus Influenza B)                              Date: _____ <input type="checkbox"/> Other    Date: _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding/Clotting Disorder <input type="checkbox"/> Convulsions in last 60 days <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Frequent Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Sickle Cell  <input type="checkbox"/> Chicken Pox _____ <input type="checkbox"/> Measles _____ <input type="checkbox"/> German Measles _____ <input type="checkbox"/> Mumps _____ <input type="checkbox"/> Hepatitis A _____ <input type="checkbox"/> Hepatitis B _____ <input type="checkbox"/> Hepatitis C _____ <input type="checkbox"/> Mononucleosis _____

### PROTECTIVE CUSTODY ARRANGEMENTS

Is there a court order in place that lists certain persons who are not authorized to pick up your child?  Yes  No  
 If yes, the following people are NOT allowed to pick up my child: \_\_\_\_\_  
 If yes, the following people ARE allowed to pick up my child: \_\_\_\_\_

**SIGN >**      **Signature of parent/guardian:** \_\_\_\_\_      **Date:** \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT** This health history is correct to the best of my knowledge, and the child herein named has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director, to order X-rays, routine tests, treatments; to maintain and/or release any medical records necessary for medical treatment or for insurance purposes as outlined under the HIPAA regulations; and, to provide or arrange necessary related transportation for me or my child. In an emergency, I hereby give permission and authorize the physician selected by The Foursquare Church to secure or administer emergency medical treatment, including hospitalization and any other emergency medical procedures which may be needed or deemed appropriate for the child named herein. I authorize the physician or dentist to call in any necessary consultants in his/her discretion. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and is given to encourage those persons who have temporary custody of my child, and said physician or dentist to exercise their best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment. In addition, I authorize my child to carry emergency medications and to use as directed; I also authorize the camp to hold and administer my child's medications in accordance with my directions.

**SIGN >**      **Signature of parent/guardian:** \_\_\_\_\_      **Date:** \_\_\_\_\_

I agree to remain fully liable and responsible for the payment of any such hospital, doctor, ambulance, dental or medical fees with the exception of the Accident Coverage as set out herein. to the extent that it applies. I further agree that in giving this permission and authorization, The Foursquare Church does not assume any responsibility or liability for the payment of such hospital, doctor, ambulance, dental or other medical fees which may be incurred. The completed forms may be photocopied and maintained by authorized personnel for trips outside of Foursquare facilities.

**SIGN >**      **Signature of parent/guardian:** \_\_\_\_\_      **Date:** \_\_\_\_\_

**ACKNOWLEDGEMENT OF INHERENT RISK/ WAIVER AND RELEASE** I ACKNOWLEDGE AND UNDERSTAND THERE ARE INHERENT RISKS ASSOCIATED WITH MANY EVENT ACTIVITIES. I WILL ASSUME THE RISK ASSOCIATED THEREWITH, WHETHER KNOWN OR UNKNOWN TO ME OR MY CHILD AT THIS TIME. I RECOGNIZE THAT MY CHILD'S ATTENDANCE AT A FOURSQUARE CHURCH EVENT IS A PRIVILEGE, AND AS A CONSIDERATION FOR THIS PRIVILEGE, MY CHILD AND I RELEASE THE FOURSQUARE CHURCH, INCLUDING ITS EMPLOYEES, AGENTS REPRESENTATIVES AND VOLUNTEERS, FROM RESPONSIBILITY FOR MY CHILD'S ACCIDENTAL PHYSICAL INJURY, INCLUDING DEATH OR ILLNESS, AND LOSS OF PERSONAL PROPERTY WHILE AT THIS EVENT OR DURING FOURSQUARE CHURCH SPONSORED TRAVEL TO AND FROM THIS EVENT. THIS RELEASE IS ALSO INTENDED TO INCLUDE ALL CLAIMS MADE BY MINE AND MY CHILD'S FAMILY, ESTATE, HEIRS, PERSONAL REPRESENTATIVE OR ASSIGNS. I GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN ALL SPECIAL TRIPS OFF THE EVENT VENUE WITH PROPER STAFF SUPERVISION.

**INDEMNIFICATION** BY SIGNING BELOW, I AGREE TO INDEMNIFY, DEFEND AND HOLD THE FOURSQUARE CHURCH HARMLESS FROM ANY CLAIM ASSERTED BY MY CHILD AGAINST THE FOURSQUARE CHURCH, INCLUDING ITS EMPLOYEES, AGENTS, REPRESENTATIVES AND VOLUNTEERS, IF MY CHILD ATTEMPTS TO REPUDIATE THIS RELEASE AFTER OBTAINING ADULTHOOD.

**PHOTO RELEASE** I HEREBY GRANT PERMISSION TO THE FOURSQUARE CHURCH THE RIGHT TO USE, REPRODUCE, AND/OR DISTRIBUTE PHOTOGRAPHS, FILMS, VIDEOTAPES, AND SOUND RECORDINGS OF MY CHILD, WITHOUT COMPENSATION OR APPROVAL RIGHTS, FOR USE IN MATERIALS CREATED FOR PURPOSES OF PROMOTING THE ACTIVITIES OF THE FOURSQUARE CHURCH.

**SIGN >**      **Signature of parent/guardian:** \_\_\_\_\_      **Date:** \_\_\_\_\_