Parental Consent and Medical Release

Please print the following information and fill in ALL the information

TO WHOM IT MAY CONCERN:
The undersigned does hereby give permission for our (my) son/daughter to attend and participate in the **LIFE 30 Hour Famine on March 15th and 16th 2013. Some of the projects are at nearby locations other than the Trinity Fellowship facility.** The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in this event.

We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital and/or emergency care facility, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. We (I) do herewith authorize the treatment by this authority, and it is granted only after a reasonable effort has been made to reach us/me the parent(s) and/or guardian(s).

We (I) the undersigned shall be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

This consent and release will be valid only for **March 15th and 16th, 2013**.

My signature also serves to indicate my willingness to take full financial responsibility for any and all medical services rendered for the named participant. My signature also serves to indicate my willingness for my Health Insurance

Company:_____ policy number: _____ to be billed for any and all medical fees and services should they be needed. We (I) hereby release Trinity Fellowship from this liability.

Name of Youth: _____ Date of Birth: _____/_____/_____

Family Doctor: _____ Doctor's Phone: (_____) _____

List any specific medical and food allergies, chronic illnesses or other conditions (put n/a if none apply): _____

_____

Emergency Phone: (_____)_____

Contact _____

Cell phone or pager number: (_____)_____

_____
1st Parent's or Guardian's signature – required

_____
Printed Name of Parent or Guardian

_____
2nd Parent's or Guardian's signature – requested

_____
Printed Name of Parent or Guardian

_____
Signed this date