Student's Name: _____

Date of Birth _____ Grade as of fall:_____

Emergency Phone #/Name_____

Address_____

Parent Email_____

Circle One: Survivor Camp (5-8) Summer Breeze (9-12)

CAMANO CHAPEL CONSENT & RELEASE FROM LIABILITY Revised 4/16/12
867 S. West Camano Drive Camano Island, WA 98282 (360) 387-7202

I, _____,the_____
(Print name of parent or guardian) *(Relationship: parent/guardian)*

of_____, do hereby consent to his/her
(Print Name of child/student)

participation in the Life Development & Student Ministries activities.

This Consent and Release Form applies to functions and/or activities including:

-Transportation to and/or from scheduled meetings, trips, outings and/or camps.

-Participation in scheduled meetings, trips, outings and/or camps.

-Medical care for child/student in case of emergency.

-Use of child's/student's photo individually or in a group setting. (Pictures may only be used for the purpose of ministry related bulletin boards, videos, brochures, and/or church directories).

I understand that I, or my designee, is responsible for the above child's safety prior to pickup and immediately upon drop off at designated pickup and drop off points. I further understand that all drivers and passengers of Camano Chapel vans and/or personal vehicles used in any event are ***required by state law to wear seat belts at all times while vehicles are in motion.***

IN CASE OF EMERGENCY, I hereby give permission to the physician selected by the ministry staff to hospitalize, secure proper treatment for and to order injections, anesthesia, or surgery for my child as named on this form. I understand every effort will be made to notify parents or guardians of child/student.

I DO HEREBY AUTHORIZE AND HOLD HARMLESS CAMANO CHAPEL, and all of its ministries and departments, each of the leaders, and each of the accompanying persons FROM ALL LIABILITY for mishap or injury of any nature whatsoever.

SIGNATURE OF PARENT/GUARDIAN_____Date_____

Alternate Emergency Phone Number_____

Doctor's Name/Phone Number:_____

Health Insurance Carrier and Policy Number: _____

Insurance Subscriber: _____

Person financially responsible: _____

Camano Chapel Participant Medical Information

All medications must be in original prescription or OTC containers with specific directions for dosage and frequency, or it will not be accepted by the person(s) registering the student.

Check all that apply:

☐ This child takes medication(s) and will self-medicate. I understand that the child will be required to turn all medication(s) (clearly labled) over to the designated adult. I further understand that it will be this child's responsibility to present himself/herself at a location designated for receiving medication(s) at frequencies/times listed below. I understand that the adult to whom this child surrenders the medication may have no medical training and will not measure dosages. This child will return the medication(s) to the adult after he/she self medicates. At the conclusion of the event/camp it will be this child's responsibility to pick up remaining medication.

☐ This child can self medicate and has permission to keep their medications with them.

(Example: Epi-pen, inhaler, etc) Please List: _____

☐ This child takes medication but is unable to self-medicate.

Medication: _____ Reason for medication: _____

Dosage & Frequency: _____

Directions: _____

☐ No medication of any type whether prescription or nonprescription may be administered to this child unless the situation is life-threatening & emergency treatment is required.

☐ I grant permission for the following nonprescription medication to be given to this child, (Excluding medication listed that causes allergic reaction).

Non-aspirin pain reliever: Yes / No # of tablets per dosage_____

Decongestant: Yes / No # of tablets per dosage_____

Antihistamine: Yes / No # of tablets per dosage_____

Throat Lozenge: Yes / No **Antacid:** Yes / No

Has child recently been exposed to contagious disease or condition such as mumps, measles, chicken pox, etc? If so, date and disease/condition: _____

Known allergies: _____

Last Tetanus shot: _____

Physical Limitations_____

SIGNITURE OF PARENT/GUARDIAN _____Date: _____

DATE	TIME	DATE	TIME	DATE	TIME