

LSCC IMPACT CAMP MEDICAL RELEASE AND LIABILITY FORM

Name _____ Age _____ Birth Date _____
Street Address _____ City _____
State _____ Zip Code _____ Phone H(____) _____ - _____ C(____) _____ - _____
School _____ Grade Level _____
Parent(s) Business Phone (____) _____ (____) _____

To whom it may concern:

The undersigned does hereby give permission for our/my child, (print name of child)
_____, to attend and participate in activities
sponsored by Lee's Summit Community Church.

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, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to his authorization. Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs. 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 activities sponsored by Lee's Summit Community Church.

Hospital Insurance Yes No

Insurance Company _____

Policy Number _____

Name of Primary Member _____

Signature _____ Date _____

Signers relation to participant: Father Mother Grandparent Other: _____

Please list any allergies or special medical problems your child has on the reverse side of this page.

Health History

Please list any allergies or special medical problems your child has: _____

Allergic Reactions: Bee Sting _____ Penicillin _____ Other _____

Food Allergies _____

List all medications currently being taken (include dosage):

List activities that are to be restricted:

Other important information:
