Pathfinder Student Ministry
2019 Medical Release

Please Print

Participant's Name _____ Birth Date_____

Address _____ Main Phone _____

City/State/Zip_____

Parent 1 Name _____ Cell _____

Parent 2 Name _____ Cell _____

The undersigned hereby authorizes and consents to any medical care, treatment or procedure, including doctor, hospital, and related services, as may be deemed necessary for the participant by an authorized representative of Pathfinder Church if the participant is incapacitated and unable to make and communicate a health care decision. The undersigned acknowledges that this authorization and consent is given in advance of any specific injury or illness, and is given to enable Pathfinder Church's authorized representative to exercise his or her best judgment as to any diagnosis or treatment which may be required. Pathfinder Church and its Representatives, including any authorized representative of Pathfinder Church, shall not have any liability or responsibility for any mistake or error in judgment made in good faith in approving any care, treatment or procedure for the undersigned. This authorization and consent shall remain in effect from October 18, 2019 through October 20, 2019 unless sooner revoked in writing by the undersigned. Third persons (including doctors, hospitals and other health care providers) may nevertheless rely upon the certification of any authorized representative of Pathfinder Church as to the current effectiveness of the authority and consent provided hereunder. Furthermore, the undersigned hereby releases any health care provider who provides any medical care, treatment or procedure to the undersigned in reliance on this instrument, from any and all claims, suits, or liabilities arising out of or with respect to said care, treatment or procedure.

IN FURTHERANCE THEREOF, the undersigned has executed this instrument as his/her free act and deed.

Participant's Signature _____ Date _____

Parent Signature_____ Date _____

EMERGENCY CONTACTS if a **parent cannot** be reached:

Name_____ Relationship_____ Phone_____

Doctor _____ Phone _____

MEDICAL BACKGROUND INFORMATION

Allergies (medications, foods, insect stings or bites, etc.):

_____

Medications taken on a regular basis (including OTC):

_____

Medical disorders, medical history or special instructions we should know about:

_____

INSURANCE INFORMATION

Medical Insurance Company _____ Phone _____

Group # _____ ID # _____ Policy # _____

Name of Responsible Party _____

A copy (front and back) of participant's insurance card must be attached.