MEDICAL CONSENT AND LIABILITY WAIVER FORM

Lamb of God Lutheran Church

3923 103rd Ave SE
Lake Stevens, WA 98258 (425)377-2173

I give my permission for ____ to
Participant's Name
participate in Lamb of God Lutheran **Youth Events** for the year of **2023-24.**

Home Phone #: ______________**Mobile**__________________**Birth Date**: __________ **F or M**
(Please Circle One)

Home Address:____

City/State/Zip: ____

Parents/ Guardian's Names: Father________________________ Mother____________________
(Please Print) (Please Print)

If at any time my child should be injured or become ill while attending a youth event, and we (parents or guardians) cannot be reached, the leader / counselor or other authorized adult has our permission to secure the necessary emergency treatment at the nearest medical facility.

I understand that it is my responsibility to provide accident and medical insurance for my child and I declare that my child is covered by such insurance. I assume all responsibility and liability for injury to my child.

I release and forever discharge Lamb of God Lutheran Church, its officers and staff, employees and other representatives against from any and all claims, damages and causes of action in law or in equity which I may have as a result of my child's participation in, attendance at, and travel to and from Youth Events

If any conduct of my child warrants them to be excused from participation in any event, I assume all responsibility for disciplinary action and picking up my child upon being notified by a counselor. Should it be necessary for my child to be return home due to medical reasons, disciplinary action or otherwise, I hereby assume all transportation costs

I, the undersigned, hereby acknowledge that I have read the forgoing, understand it's contents and have signed the same as my own free act and deed.

____ ______________________

Signature of Parent / Guardian **Date**

Phone Numbers: **Additional Emergency Numbers:**

Father's Work ________________________ ______________________________

Mobile Phone ________________________ **Name** **Number**

Mother's Work ________________________ ______________________________

Mobile Phone ________________________ **Name** **Number**

Doctor ______________________________ **Dentist** ______________________________

Phone Numbers: ________________________ ______________________________

Health Plan Carrier: ___________________________ **Policy No.** ______________________

Policyholder's Name:___________________________ **Insurance Agent Phone #** ______________

ADDITIONAL INFORMATION:

Please list on the back any current health problems; directives for medical and / or emergency care, etc.)
Please also list any **general allergies**, any **allergies to medications** and/or pre-existing conditions.

☐ <= ***Or*** Initial
"I have no known allergies, allergic reactions to any medication or pre-existing conditions"