**Medical Authorization and Release Agreements**

 **for Press On Ministries**

Name of Participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_St\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of an emergency notify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_** Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **Medical History** Asthma\_\_\_Sinusitis\_\_\_\_Bronchitis\_\_\_\_KidneyTrouble\_\_\_\_Hayferver\_\_\_

Heart\_\_\_\_Diabetes\_\_\_\_Dizziness\_\_\_\_Stomach Upset\_\_\_Migraines\_\_\_

**Allergies:** Foods\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Penicillin or other drug(name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insect Stings/Bites\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Poison sumac,oak,or ivy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous operations or serious illnesses**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any current medications you are taking (list**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Release Agreement**

I, the undersigned being the parent/guardian grant permission for the minister or sponsor in charge to obtain necessary medical attention in case of sickness or injury to my child or ward. I hereby verify that the above information is correct and that it is the responsibility parents/guardians to contact Press On Ministries with any changes.

In consideration of my child being **permitted to attend Press On Youth Center** and utilize the programs, facilities, services and equipment or participate in the center events. I, the parent/guardian agree to indemnify and hold harmless the center, its Directors, Employees, and Volunteers from all claims, demands, liability or judgments arising out of or during my child’s use of the youth center facilities, and equipment or participation in the centers programs or events.

Dated this \_\_\_\_\_\_\_ day of\_\_\_\_\_\_\_\_\_\_\_\_\_2017/18 State of\_\_\_\_County of\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Photo Release**

 I, the undersigned parent/guardian release use of any and all photographs that include **me/us** **and my/our minor children** to be used by Press On Ministries or InFaith Missions publications, displays, brochures, face book or website.

Dated this \_\_\_\_\_ day of\_\_\_\_\_\_\_\_\_\_\_\_\_2017/18 State of\_\_\_\_\_\_\_County of\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 We reserve the right to send home a child(s) do to misconduct; the parent/guardian will be notified. Depending on the circumstances the child(s) may need to be accompanied by parent/guardian in order to return; upon such time the Directors feel the behavior of the child(s) has improved and can return on their own for the safety of all.