Episcopal Diocese of Iowa Emergency Information, Medical Release, and Media and Photo Release

For the year January 1, 2024 through December 31, 2024

Adult Volunteers and Youth must complete Please print in ink:

Participant's Name: ____

Gender Identity & Preferred Pronouns ______________________ Date of Birth: __________

Home Address ______________________ City ______________ State ____ Zip __________

Youth Cell Phone __________________ Youth Email ____________________________

Parent/Guardian Names ____

Parent/Guardian Phone: Cell (1) _______________ Cell (2) _________________

Emergency contact: ________________________ Relationship: ____________________

Emergency Contact's Phone: Home________________ Work/Cell___________________

Medical insurance company: ________________________ Policy #:_________________

Physician: ______________________________ Office phone: ____________________

Dentist: ______________________________ Office phone: ____________________

I the undersigned have legal custody of the Participant, a minor.

Parent/guardian signature: ___________________________________ Date: __________

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.

I understand that there are inherent risks involved in any ministry or athletic event, and I hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that I/he/she is injured and requires the attention of a doctor, I consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I affirm that the health insurance information provided above is accurate at this date and will, to the best of my knowledge, still be in force for the participant named above. I also agree to bring my child home at my own expense should he/she become ill or if deemed necessary by the Church retreat leaders.

Parent/guardian signature: ____ Date: ______________

Participant's signature if over 18: _____________________________________ Date: ______________

Media and Photo Release: The participant agrees to grant the Church permission to record via photographs and/or video their participation at this youth event and further agrees that any or all material recorded may be used, in any form, as part of any future production made by the Church and that such use shall be without payment of fees, royalties, special credit, or other compensation. This form is valid until such time that it is revoked by the undersigned.

Participant signature: ______________________________ Date: ____________

Parent/guardian signature: ___________________________ Date: ____________

MEDICAL HISTORY

This information will be kept confidential and shared only with adult team members as necessary.

Please attach additional sheets of paper as necessary with the following information.

1. Are there any life circumstances (death, divorce, change in family circumstances, change of school, etc) or health conditions of which the adult staff should be aware? Does your child have a physical, behavioral, or emotional disability, a 504 plan or an IEP?

2. Include names of medications and dosages that must be taken:

- Youth who bring medication(s) to events must bring only enough medication for the length of the event.
- All medications must be in their original containers if possible. Explicit instructions on medication dosages and schedule of administration must be included.
- All medications should be turned into the adult responsible for distribution of medications on the weekend.
- The medical release form should be completed each calendar year. If there are changes, it is expected that a new form will be completed.

3. Please list any dietary restrictions or food allergies:

4. Does this participant have allergies to?

• Pollens • medications • food • insect bites • other

List specific allergens

If there is an exposure, what should be done?

5. Does participant suffer from, or has ever experienced, or is being treated currently for any of the following:

• Asthma • epilepsy/seizure disorder • Diabetes • physical handicap • frequently upset stomach • heart trouble • other

Explain:

6. Date of last tetanus shot: ___________________

7. Does participant wear? • glasses • contact lenses