

**MEDICAL CONSENT AND LIABILITY AND ACTIVITY RELEASE FORM**

**Must be completed and carried by all participants. Copy must be given to group leader.  
Must be signed by parent or guardian of participants under 21.  
Please type or print legibly in ink.**

PARTICIPANT NAME: (Last) \_\_\_\_\_ (First) \_\_\_\_\_  
 BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ MALE: \_\_\_\_ FEMALE: \_\_\_\_\_ SS#: \_\_\_\_\_  
 HOME ADDRESS: \_\_\_\_\_  
 CITY/STATE/ZIP: \_\_\_\_\_  
 HOME PHONE: ( ) \_\_\_\_\_ DAY PHONE: ( ) \_\_\_\_\_  
 CUSTODIAL PARENT/GUARDIAN: \_\_\_\_\_  
 HOME PHONE: ( ) \_\_\_\_\_ DAY PHONE: ( ) \_\_\_\_\_  
 HOME ADDRESS (IF DIFFERENT) \_\_\_\_\_  
 HEALTH PLAN CARRIER: \_\_\_\_\_  
 NAME OF INSURED: \_\_\_\_\_  
 RELATIONSHIP TO PARTICIPANT: \_\_\_\_\_  
 SS# OR POLICY HOLDER OR INSURANCE ID NUMBER: \_\_\_\_\_  
 FAMILY DOCTOR: \_\_\_\_\_  
 OFFICE PHONE: ( ) \_\_\_\_\_ MEDICAL EXCHANGE: ( ) \_\_\_\_\_  
 FAMILY DENTIST: \_\_\_\_\_ OFFICE PHONE: ( ) \_\_\_\_\_  
 SECOND PARENT OR EMERGENCY CONTACT PERSON: \_\_\_\_\_  
 RELATIONSHIP TO PARTICIPANT: \_\_\_\_\_  
 HOME PHONE: ( ) \_\_\_\_\_ DAY PHONE: ( ) \_\_\_\_\_

Please specify if any health insurance pre-certification, notification, or other requirements exist for the participant: \_\_\_\_\_

Participants will be covered by a limited accidental death and accidental bodily injury policy (Security Insurance Company of Hartford through Lutheran Trust) that provides reimbursement up to a minimal dollar amount for medical expenses incurred as a result of purely accidental injuries sustained while at the Servant Event. This coverage is secondary to all other insurance coverage available to the participant and will make payment only if such other insurance (participant's primary insurance policy) is not adequate to cover the medical expenses resulting from an accidental injury sustained while at the Servant Event.

Medical Card Copy Front

Medical Card Copy Back

**CONSENT (continued)**

I understand that the Servant Event for which this Medical Consent and Liability and Activity Release Form is being given is described as follows: (DESCRIPTION OF SERVANT EVENT, INCLUDING LOCATION, DATES, SPONSOR AND ACTIVITIES, PARTICULARLY ANY HAZARDOUS ACTIVITIES.) \_\_\_\_\_

I hereby consent to participation of myself (or of my child) in the above-described Servant Event. I have read the informational materials regarding the planned activities. I am aware that in addition to activities such as Bible study, worship, sight-seeing, using public transportation, and meal functions, the participant also may be asked to participate in various servant activities that may involve additional risks, such as \_\_\_\_\_

I understand that I have a duty to provide primary accident and medical insurance for myself (or for my child) and I declare that I am (or my child is) covered by primary accident and medical insurance.

I RELEASE AND FOREVER DISCHARGE THE LCMS YOUTH MINISTRY, THE LUTHERAN CHURCH—MISSOURI SYNOD (SYNOD), \_\_\_\_\_(NAME OF HOME CONGREGATION), AND \_\_\_\_\_(SITE OF SERVANT EVENT), THEIR AGENTS AND SERVANTS, SUCCESSORS AND ASSIGNS, DIRECTORS, TRUSTEES, OFFICERS, EMPLOYEES, AND OTHER REPRESENTATIVES FROM ANY AND ALL DAMAGES OF MY [OR MY CHILD'S] PARTICIPATION IN, ATTENDANCE AT, AND TRAVEL TO AND FROM THE SERVANT EVENT. FURTHERMORE, I DO HEREBY EXPRESSLY STIPULATE, AND AGREE TO INDEMNIFY AND HOLD FOREVER HARMLESS THE DYM, SYNOD, \_\_\_\_\_(NAME OF HOME CONGREGATION), AND \_\_\_\_\_(SITE OF SERVANT EVENT), ITS AGENTS AND SERVANTS, SUCCESSORS AND ASSIGNS, DIRECTORS, TRUSTEES, OFFICERS, EMPLOYEES, AND OTHER REPRESENTATIVES AGAINST LOSS FROM ANY AND ALL PRESENT OR FUTURE CLAIMS, DEMANDS, OR ACTIONS IN LAW OR IN EQUITY THAT MAY HEREAFTER BE MADE OR BROUGHT BY ME OR MY CHILD, BY ANYONE ON BEHALF OF ME OR MY CHILD, OR BY ANYONE ELSE ON THEIR OWN BEHALF FOR DAMAGES OR ANY OTHER LEGAL OR EQUITABLE REMEDY ON ACCOUNT OF ANY INJURY, ILLNESS, PHYSICAL CONDITION, INCONVENIENCE, OR LOSS SUSTAINED BY ME OR MY CHILD DURING THE SERVANT EVENT OR TRAVEL TO AND FROM THE SAME.

I, the undersigned, hereby acknowledge that I have read the foregoing, understand its contents, and have signed the same as my own free act and deed.

**FOR PARTICIPANTS AGE 21 AND OVER:**

\_\_\_\_\_  
Participant Signature                      Date                      Witness

**FOR PARTICIPANTS UNDER AGE 21:**

\_\_\_\_\_  
Parent/Guardian                      Date                      Witness  
(If participant is under 21)



### EMERGENCY MEDICAL INFORMATION FORM

Please complete so that health providers can be aware of your personal health needs.  
Must be completed by all Event participants.

Name of Participant: \_\_\_\_\_

Does participant have: (if "yes" explain)

\_\_\_ Yes \_\_\_ No      ALLERGIES? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      HEART CONDITION? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      OTHER? \_\_\_\_\_

Is participant subject to: (If "yes" explain)

\_\_\_ Yes \_\_\_ No      HEADACHES? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      SEIZURES? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      MOTION SICKNESS? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      FAINTING? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      SLEEP WALKING? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      UPSET STOMACH? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      OTHER? \_\_\_\_\_

Does participant have reaction to: (If "yes" explain)

\_\_\_ Yes \_\_\_ No      BEE STING? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      PENICILLIN? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      OTHER DRUGS? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      POISON IVY, OAK, SUMAC? \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No      OTHER? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No      Has the participant had any serious illness or surgery within the past ten years?  
Please list: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No      Does the participant have any condition that would prevent him/her from  
participating in any Servant Event activities?  
Please list: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No      Does the participant take any prescription medication?  
Please list: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No      Are any drugs ineffective in treatment? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No      Is the participant diabetic? Medication? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No      Does the participant have any sight or hearing impairment? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No      Does the participant wear contact lenses? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No      Does the participant wear hearing aids? \_\_\_\_\_

Blood type: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

**A current tetanus shot is required. After 5 years, another tetanus shot is recommended.**

Please indicate ANYTHING else that leaders should know to help avoid or deal with any medical situation that might arise: \_\_\_\_\_

\_\_\_\_\_