

Parental Consent for Breakaway Retreat '09

In my absence I authorize the Student Ministry of The University Baptist Church to administer medications as needed or directed below.

The following is the list of over the counter drugs that have been approved for use. The Student Ministry staff would dispense these only as needed. Please circle any of these items **NOT** to be given to your child.

- | | |
|--|-----------------------------------|
| Acetaminophen(Tylenol) | Calamine Lotion |
| Benadryl | Sudafed(decongestant) |
| Cepacol (Lozenges, mouthwash) | Betadine for wound care |
| Pepto Bismol | Cepastat (Lozenges) |
| Hydrogen Peroxide for wound care | Milk of Magnesia |
| Chlor Trimeton (antihistamine) | Neosporin Ointment for wound care |
| Mylanta II | Cortisone Cream |
| Polysporin Ointment for wound care | Gatorade |
| Actifed (decongestant and antihistamine) | Caladryl Lotion |
| Immodium | |

Authorization to Medicate Your Child

Child's Name: _____ Grade: _____ Date of Birth: _____

Please complete a line for each medication sent. All medication must be in original containers with the prescription instructions **from your child's pediatrician**, in your child's name. It **must** be checked in with a member of the Student Ministry staff upon arrival.

I hereby request and authorize the Student Ministry staff, to give the following medication(s) to my child:

Currently taking any medication? Yes or No

If yes, what?

NAME OF MEDICATION	DOSAGE	FREQUENCY	WHAT IT'S FOR?

List Allergies (Food, drugs, etc...)

Physical Disorders (Diabetes, Epilepsy, Asthma, Fainting, Heart Condition etc...)

Date of last tetanus shot? _____ Does your child dehydrate easily ? Yes or No

Can child take part in athletic activities including jumping, running, swimming and water sports?
Yes or No

As the parent (or legal guardian) of _____, I certify that I have been informed that, as a participant in "Breakaway Retreat 2009", my child will be participating in an overnight retreat on November 13-14th, 2009 in the homes of church members. Completion of this form gives medical authority to the adult representatives of the Student Ministry of The University Baptist Church.

By signing the bottom portion of this form, I am promising that the information above is accurate.

I also state, that if I allow my child to participate in Breakaway Retreat 2009, my child is physically fit and has the necessary skills to participate in this activity.

Signature of Parent/Legal Guardian: _____

Medical Treatment Authorization

Child's Name: _____

Mother's Name: _____ Father's Name: _____

Home Phone Number: _____ Cell Phone Number: _____

E-mail: _____

Doctor's name: _____ Doctor's Phone Number: _____

Insurance Company: _____ Policy #: _____

Insurance Company Phone Number: _____

Emergency Contact Person

In an emergency, if a parent or legal guardian can not be contacted, the following individual has the authority to make decisions regarding my child:

Name: _____ **Phone #:** _____

Relationship to Child: _____

IMPORTANT – THIS BOX MUST BE COMPLETED FOR ATTENDANCE

I understand that there are always risks inherent in retreat activities, therefore, I agree to release and not hold The University Baptist Church and its ministry representatives liable for accidents that may occur on or off the church property during my child's stay. The health history provided above is accurate as far as I know, and the child herein described has my permission to engage in all prescribed retreat activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the retreat director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the retreat director to secure and administer treatment, including hospitalization and anesthetization, for the child named above. I also understand and agree to abide with my physician's recommendations.

Signature of Parent/Guardian: _____

Witness: _____ Date: _____