

PERMISSION AND MEDICAL CONSENT

As parent or legal guardian, I hereby give permission for my child to participate in the following activity (the "Activity"):

organized by SCF Youth Ministry

Name of Activity Unashamed 2010 Spring Youth Retreat

Child's Full Name _____

Sex _____ Last _____ Birthday _____ First _____ Middle _____ Age _____

Parent or Guardian Name _____

Home Address _____

Home Phone _____ Cellphone: _____

If not available in an emergency, notify :

1. Name _____ Phone (_____)
Address _____

or 2. Name _____ Phone (_____)
Address _____

Does this child have any of the following allergies :

Penicillin _____ Other : _____

Other Drugs _____

Insect Stings _____

Ivy Poisoning, etc. _____

Hay Fever _____

Food _____

Does this child have any medical or health problems, and has this child had any chronic or recurring illness or illnesses, which would have an effect on the child's participation in this Activity?

Yes No

If yes, describe the problems or illnesses _____

State the name, address, medical specialty and phone number of this child's family physician and of any other physician who should be consulted in the event of emergency or medical problems involving this child :

State the name, address, and phone number of this child's dentist (and orthodontist if applicable) :

Is there medical or hospitalization insurance which provides benefits for this child? _____

If so, please indicate:

Name of Insurance Co. _____

Address _____

Policy No. of Insurance Policy _____

Name of Policy Holder _____

Phone No. of Insurance Co. (_____)

Indicate the date of this child's last tetanus shot _____

Are there any activities, such as strenuous activities, to be restricted for this child? _____

If so, describe: _____

Is this child on any medications? _____ If so, please state the medication : _____

If so, will this child be bringing to the Activity the medications that he/she should be taking? _____

Describe any dietary restrictions that this child is required to observe _____

Other comments or suggestions from the parent or guardian concerning this child: _____

I further understand that, in the event my child requires medical or dental treatment while engaged in the Activity, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the ministry's sponsor or any adult counselor acting on behalf of the ministry with respect to the Activity, as agent for me, to consent to any X-ray examination; injections; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medications being taken, medical problems and other pertinent information. My child has permission to participate in all prescribed

In addition, I understand that Shanghai Community Fellowship (SCF) and/or the SCF youth staff is not responsible for injuries which may occur during the Activity. I hereby voluntarily waive any claim against SCF.

Signature _____ Date _____
(Parent or Guardian)

Print Full Name _____ Date _____