I give my permission for _____ (child's name) age _____ to go on all church sponsored trips that may be offered during the 2018-19 school year. I understand that trips will be under the supervision of a staff member(s) of The Donelson Fellowship and/or adult volunteer(s) approved by the church staff and that my child may be transported in a vehicle rented by the church, a personal vehicle of a staff member or volunteer, or a contracted bus.

I understand this may include, but not be limited to, summer camps, weekend retreats, missions trips, amusement parks, or community service and could include travel to other states or out of the country.

Authorization to Consent to Emergency Treatment

In case of medical emergency, I, the undersigned, parent/guardian of the below minor, do hereby authorize The Donelson Fellowship as agents for the undersigned in our absence, to consent to X-ray examination, anesthetic, medical or surgical diagnosis or treatment, hospital care which is deemed advisable by and is to be rendered under the general or special supervision and upon the advice of a licensed physician or surgeon, whether such diagnosis, treatment, or hospital care by required or not, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent in any medical emergency to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of best judgment may deem advisable.

Indemnification

I, the undersigned, agree to release, hold harmless, and indemnify The Donelson Fellowship, its trustees and officers, its agents, representatives and employees from and against any and all liability, lawsuits, claims, damages or claims for injuries to my son or daughter which are not the result of gross negligence, intentional neglect or willful or wanton conduct by the Church or its agents, representatives, or employees.

_____ _____
Parent Signature Date

_____ _____
Witness Signature Date

(Any adult including a spouse or family member can serve as a witness.)

*****OVER*****

Medical Form

Name _____
Age _____
Address_____
City _____ State _____ Zip _____

In case of emergency notify:

Name _____
Phone _____
Family Physician _____
Phone _____
Family Insurance Company
_____
Policy Number
_____
Immunizations:
Tetanus _____ Polio Booster _____
Measles _____ Mumps _____

Past Medical History (please circle):

Asthma	Sinusitis	Bronchitis	Kidney Trouble
Hay Fever	Diabetes	Dizziness	Heart Trouble

Allergies (list type):
Food
_____

Penicillin or other drug (name)
_____

Insect stings (bites)
_____

Poison sumac, oak, or ivy
_____

Previous operations or serious illness
_____
_____

Any current medications (list)
_____
_____

Special diet (name)
_____

Childhood Diseases:
Chicken Pox _____ Measles _____
Mumps _____ Whooping Cough _____
Other _____