River of Life Emergency Permission & Health Form

*All participants must have a completed form on file before participating in ROL activities.

FOR YOUTH PARTICIPANTS:
I hereby give my permission for River of Life counselors to seek medical help for my child, _____, in any situation they deem merits such help. I also give permission for medical and emergency response personnel, in my absence, to administer any treatment, including surgery, that they deem to be necessary during the time my child is en-route to and from, and participating in, the River of Life event to be held at Tifton First United Methodist Church.

My child has my permission to be assigned to a work team that will paint, build and repair porches, and do other home repairs and improvements. (Any type of work I have not approved has already been noted on my child's Registration Form.) I will not hold River of Life, its Directors, Coordinators, Host Church, Participating Churches, or Counselors responsible for any injuries incurred by my child. I WILL NOT allow my child to drive during the event.

Signature of Parent/Guardian _____ Date _____

FOR ADULT PARTICIPANTS:
I hereby give my permission for River of Life counselors to seek medical help for me, _____, if there is any situation they deem merits such help and I am unable to participate in that decision. I also give permission, if necessary, for medical and emergency response personnel, to administer any treatment, including surgery, they deem to be necessary during the time I am en-route to and from and participating in, the River of Life event to be held at Tifton First United Methodist Church.

Signature of Adult Participant _____ Date _____

FOR ALL PARTICIPANTS:

1.Is the participant named above covered under hospitalization insurance?YES NO. (If no, go to line5)

2.Does the participant have an insurance card? YES NO
IF YES, ATTACH A COPY OF THE CARD UNDER WHICH THE PARTICIPANT IS COVERED. THEY ARE NOT CONSIDERED REGISTERED UNTIL THIS CARD IS SUBMITTED.

3. Name of insurance company
_____

Policy Number _____ Group Number _____

4. Name of Person in which Insurance is carried:
_____

5. Family Physician : _____ Physician's Office Telephone:
_____

6. Primary Emergency Contact: _____ Number: _____

* Secondary Emergency Contact : _____ Number: _____

7. Please list any allergies to medications, foods, insect stings, etc.

_____
_____
_____
_____
_____
_____
_____
_____

8. List of regular medication and schedule:
_____
_____
_____
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_____

9. Are there any medical conditions that are relevant to the participant's work and involvement at ROL?
_____
_____
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_____
_____