

# NYC 2011 USA Student Medical and Liability Release

## Personal Information

|                       |                                 |                   |
|-----------------------|---------------------------------|-------------------|
| First Name: _____     | Last Name: _____                | Gender: _____     |
| Street Address: _____ |                                 | City: _____       |
| State/Province: _____ | Zip/Postal Code: _____          | Country: _____    |
| Email Address: _____  |                                 | Home Phone: _____ |
| S.S. #: _____         | Birth Date: _____<br>(mm/dd/yy) | Cell Phone: _____ |
| District Name: _____  |                                 |                   |

## Parent/Guardian Contact Information

|                  |                    |
|------------------|--------------------|
| Name _____       | Relationship _____ |
| Home Phone _____ | Work Phone _____   |
| Cell Phone _____ | Email _____        |

## Health Information Necessary for Proper Care and Protection

\*For additional space, use back of page for answers

*In order to assist medical personnel in an emergency situation, please provide the following:*

|  |   |
|--|---|
| <p>Describe any health issues or diagnoses:</p> <p>Please state any limitations:</p> <p>Any allergies to medication?</p> <p>List all current medications, dosages, and directions:</p> <p>Date of last tetanus shot:</p> | <p>Family Physician: _____</p> <p>Physician Phone: _____</p> <p>Recent exposure to communicable disease?<br/> <input type="checkbox"/> Yes                      <input type="checkbox"/> No<br/>           If yes, explain:</p> <p>Do any foods cause allergic reaction?<br/> <input type="checkbox"/> Yes                      <input type="checkbox"/> No<br/>           If yes, explain:</p> <p>Is there anything else we should know?</p> |
|--|---|

## Insurance Information

|                      |                          |
|----------------------|--------------------------|
| Primary Name: _____  | Insurance Company: _____ |
| Policy Number: _____ | Group #: _____           |

**Authorization for Medical Treatment & Parent/Guardian Permission**

In the event I cannot be reached, I authorize and direct any adult Nazarene Youth International employee or volunteer representing the Church of the Nazarene to make emergency medical decisions for my child. Therefore, I (name of parent or guardian), \_\_\_\_\_, hereby authorize that emergency medical and/or surgical care may be provided for my son/daughter \_\_\_\_\_, at my expense.

I also hereby release and discharge the General Board of the Church of the Nazarene, and its affiliates, along with any other chaperoning adult employees or volunteers of Nazarene Youth International, its agents, employees, officers, directors, affiliates, successors, assigns and all other, from any and all claims, demands, expenses, personal injury, wrongful death, causes of action, lawsuits, damages and liabilities of every kind and natures, whether known or unknown, in law or equity, that I or my child ever had or may have, arising from or in any way related to my child's participation in any activities associated in any way during the Nazarene Youth Conference, 2011. I have full knowledge as to such activities, and I have full knowledge of the probable risks involved. Except for those limitations named in this health form, I certify that \_\_\_\_\_ (name of child), is healthy and fit to participate in all such activities.

Further, I acknowledge that NYC and/or its agents will be taking photographs and/or videos of the NYC 2011 events and that \_\_\_\_\_ may appear in those photographs and/or videos. I hereby give my permission to NYC and/or General Board Church of the Nazarene to utilize event media in all forms and in all manners for marketing, promotional, and future event development.

In addition, I acknowledge that this release form also includes travel dates to and from the event with my sponsoring district.

I hereby give permission to share my student's contact information with the USA/Canada higher education institutions.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship \_\_\_\_\_

**The following section must be completed by a Notary Public.**

Before me, a Notary Public, in and for said County and State, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, personally appeared \_\_\_\_\_ and acknowledged execution of the foregoing.

IN WITNESS WHEREOF, I have hereunto set my hand and Notary Seal.

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Notary Public Signature \_\_\_\_\_

Commission expiration date \_\_\_\_\_

Notary Seal:

**PLEASE SIGN, NOTORIZE, AND MAIL THESE FORMS TO YOUR DISTRICT NYC COORDINATOR.**

*Todd Owens  
3101 N. Benton Rd.  
Muncie, IN 47304*

|               |  |
|---------------|--|
| Form Received | For NYC Office Use Only<br>Date: _____ |
|---------------|--|