

Appendix 10 – Waiver & Medical Release Form for Overnight and Special Events

Activity: _____ Date(s): _____

Place: _____ Approved Workers: _____

Name of Parent/Guardian _____ PhoneNo. _____

Name of Child/Youth _____ Age _____

Address _____ PC _____

Date of Birth: _____ Health Card Number: _____

****Your child must be covered by Provincial Health Insurance or equivalent medical insurance.*

Does your child have any severe/any life-threatening allergies (bee stings, food, penicillin, other drugs) or medical conditions? **Yes** **No** If yes, please explain:

Does your child carry an EpiPen or Inhaler? **Yes** **No** If yes, please explain:

Note: Appendix 11 should be completed in addition to this form.

Does your child have any physical, emotional, mental or behavioural concerns or limitations that our staff should be aware of? **Yes** **No** If yes, please explain:

Is your child/youth bringing any medication with him or her? **Yes** **No**
If Yes, please explain:

Medication must be in the original container and must be left in the possession of the event leaders.

Please check the box(es) if your child/youth currently, or within the last three months, has had any of the following:

- | | | | |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Severe Stomach Ache |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles (Red) | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Measles (German) | <input type="checkbox"/> Tonsillitis |

Other _____

Date of last Tetanus shot: _____

Family Physician _____ Physician's Phone # _____

Waiver – Please Read Carefully

I/we, the parents or guardians named above, authorize the ministry staff of Breslau Evangelical Missionary Church to sign a consent for medical treatment and to authorize any physician or hospital to provide medical assessment, treatment or procedures for the participant named above.

I/we, named above, undertake and agree to indemnify and hold blameless the Ministry Staff, Breslau Evangelical Missionary Church, its Pastors and Board of Deacons from and against any loss, damage or injury suffered by the participant as a result of being part of the activities of the Breslau Evangelical Missionary Church, as well as of any medical treatment authorized by the supervising individuals representing the church. This consent and authorization is effective only when participating in or traveling to events of the Breslau Evangelical Missionary Church.

Parent/Guardian's Signature: _____ Date: _____

Printed Name: _____

Breslau Evangelical Missionary Church
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