Pointe of Grace Lutheran Church

Children, Youth & Family Ministry

Medical Release and Code of Conduct Form

Name:_____ Birthdate_____ Age _____

Parent or Guardian Name(s): _____

Phone Numbers :_____

Home phone # Cell Work

Home Address:_____

E-Mail :_____ Grade & school name:_____

Covenant of Conduct

I agree to participate fully in all activities of Pointe of Grace's Lutheran Church CYFM events that I attend. I agree to respect all other participants, chaperones, drivers and any other persons involved in the events. I will not abuse anyone verbally or physically. I agree to respect my own body by not possessing or using any alcohol, drugs or tobacco. I agree not to bring or possess any weapons of any kind. I agree to remember that I represent the congregation of Pointe of Grace Lutheran Church, and all Christians with my actions. Should I break this covenant, I agree to accept the consequences determined by the chaperones or youth leaders. If it is determined that my behavior warrants my leaving this event, travel to my home or other costs will be at my own expense or that of my parents or guardians.

Participants signature:_____ **Date:**_____

Photo Release

I ☐ **do** ☐ **don't** want photos of my student taken or used for publicity (Facebook, newsletter, website, etc).

Parent's Signature:_____ **Date:**_____

Emergency Medical Release

I understand that in the event of an emergency, or if any medical or surgical care becomes necessary for _____, every attempt will be made to contact me. If I am unavailable, I grant those in charge of the event, permission to administer first aid and to authorize medical attention as recommended by a licensed physician. I agree to pay all medical costs involved in such emergency treatment. I release and discharge Pointe of Grace's Lutheran Church and/or its representatives involved in this event from any liability whatsoever in exercising this permission.

Parents/ Guardian signature:_____ **Date:**_____

Other Important Information

Physician's Name_____ Phone Number_____

Insurance Company Name & Policy Number:_____

Emergency Contact Name & Phone Number:_____

Allergies, including all drug allergies, and any special medical conditions or needs: (use back if necessary):

Date of last tetanus shot:_____