CENTRAL DISTRICT CONFERENCE
Annual Meeting , June 20-22, 2024, College Mennonite Church, Goshen, Indiana

Medical Release Parent Permission
Child's Name_____ Age _____

PARENT INFORMATION
Parent/Guardian_____ Phone (c)_____ (H) _____
(W)_____ Email_____ Emergency
Contact_____Phone (c)_____ (H)_____(W)_____
Email_____

HEALTH INFORMATION

Allergies
Does your child have any allergies? ❑ Yes " No If yes, List:
Please explain symptoms/treatment needed:

Asthma
Does your child ever experience symptoms of asthma? ❑ Yes ❑ No If yes, explain usual symptoms and any treatment needed:

Medication
Does your child require prescribed medication? ❑ Yes " No List medications and dosages:

Health Concerns/Physical Impairments
Please note any physical impairments, health concerns, special accommodations, etc. needed for your child. Please be specific.

Anything else children's staff should be aware of

I, the undersigned, certify that I am the parent or legal guardian of _____ (hereafter the "minor child").

I give my consent to have my minor child participate in the children's activities of Central District Conference: (hereafter"the activity") on or about June 20-22, 2024.

I recognize that there are risks involved in participating in this activity and hereby assume all risk of injury, harm, damage, or death to my minor child in connection with his/her participation in this activity.

To the fullest extent permitted by law, I release Central District Conference, its directors, employees, and representatives from any injury, harm, damage or death which may occur to my minor child while participating in the activity and agree to save and hold harmless Central District Conference, its directors,

employees, and representatives from any claims arising out of my minor child's participation in the activity.

Further, being the parent or legal guardian of the minor child, I do consent to any medical, surgical, x-ray, anesthetic, or dental treatment that may be deemed necessary for my minor child. I understand that efforts will be made to contact me prior to treatment but, in the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. As parent or legal guardian, I understand that I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital care or treatment that is given to my minor child. Any insurance policy of the church or organization sponsoring this event will be used as the secondary coverage.

_____
Parent/Guardian Signature

_____
Date

Caregivers: Please take completed forms along on field trip & keep on hand while at the conference site.