

Amt. Pd _____ Sch. _____
Amt Due _____ Date _____

Episcopal Diocese of Montana

Registration/Health History/Medical Release Form

Authorization / Release

e-mail address: _____

Participant (child's) Name _____
Male / Female _____ Birth date _____ Last _____ First _____ Middle _____ Nickname _____
Grade Next Year _____ Church you are attending? _____
Address _____ City _____ State _____ Zip _____ Home Phone _____
Parent (or guardian) Name _____ Cell Phone _____
Place of Employment _____ Work Phone _____
Parent (or Guardian) Name _____
Place of Employment _____ Work Phone _____

If parent(s)/guardian(s) are not available in case of emergency, please notify:

1. _____
Name _____ Day Phone _____ Relationship to Child _____
2. _____
Name _____ Day Phone _____ Relationship to Child _____

I (my child) will be attending **Fall Youth Presence at Diocesan Convention September 25 – 27, 2009**

Participation: I give permission for my child to participate in all activities, field trips, swimming activities and to be transported as part of the Camp Marshall or Youth Programs experience. I also give my permission to use any photographs and/or videos of my child for future promotional purposes.

Authorization to consent to treatment of minors: (I) (We), the undersigned, parent(s) or guardian(s) of the above mentioned youth, a minor, do hereby authorize The Episcopal Diocese of Montana, Director of Camp Marshall & Youth Programs or his Designee as agent(s) and/or chaperone(s) for the undersigned to consent to any x-ray, examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon who is licensed to practice in the state of Montana, whether such diagnosis or treatment is rendered at the office of said physician or at any hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgement may deem advisable.

This authorization shall remain effective through the completion of the registered program, unless sooner revoked in writing delivered to said agent(s).

I understand the above and have completed the information to the best of my ability. The health history provided is correct to the best of my knowledge and the person herein described has my permission to engage in all activities except as noted.

X _____ **X** _____
Signature of Parent or guardian _____ Date _____ Witness _____ Date _____

Note: If there is a person who is not authorized to have contact with your child please provide the director with documentation concerning this matter.

Health History

First time with this program? _____ Used to being away from home? _____

Allergies: _____

Family Doctor: _____ Phone: _____

Insurance Company _____ Group Number _____

Current Medications: _____

Any current or past health conditions we should be aware of? _____

Date of Last Tetanus injection or booster _____ Special Diet? _____

Anything else about this youth you would like us to know? _____

Optional: Has, or is, your child receiving counseling, and for what reasons? _____

What can we do to continue to promote healing for your child? _____

Behavior: I realize that Camp Marshall/ Episcopal Youth Program is an experience of living in Christian community. Out of respect for myself and other campers I give my word to live by these non-negotiable norms. I realize that if I choose not to live by these norms, I risk being sent home at my parents' expense.

1. No illegal drugs, tobacco products or alcohol, firearms, weapons, or fireworks.
2. No girls in the boys' area or boys in the girls' area, after hours.
3. Stay on camp property (Unless with a supervised activity).
4. No sex.

Youth Signature _____ Date _____ Parent (Guardian Signature) _____ Date _____