Transportation Release Form
Indian Nations Presbytery • YouthQuake 2013
(to be filled out by Parent/Guardian)

I, _____do hereby release

_____ Church,

and any of its representatives, whether paid staff or volunteer from any and all liability where the transportation of my child via church-provided transportation is concerned.

I further agree to release any and all persons involved jointly with my child in transportation (i.e. other children/youth in transportation vehicles with my child) from any and all liability where transportation of my child is concerned, via church-provided transportation. I understand that drivers in the church transportation program are not necessarily certified as "commercial drivers" as constituted by a "CDL" or commercial driver's license.

Youth Participant's name (please print): _____

Signature of Parent/Guardian: _____

Please give us a phone number where you may be contacted:

Phone: _____

NOTE: Release forms without parent's signature and telephone number will not be accepted.

YOUTH QUAKE 2013
PARENT/GUARDIAN CONSENT FORM

Child's Name (Last)	(First)	(Middle)	
Address	City	State	ZIP Code
Name of Facility (Camp/Church/School) **Youth Quake 2013**			
Address **Canyon Camp, 31600 Camp Road**	City **Hinton**	State **OK**	ZIP Code **73047**
Dates of Attendance			

As the parent or legal guardian of my child, _____ I hereby consent for my child to attend and participate in all activities provided as described above.

I also give permission for images of my child, captured during regular and special youth activities through video, photo and digital camera, to be used solely for the purposes of Indian Nations Presbytery, Presbyterian Church (U.S.A.), promotional material and publications, and waive any rights of compensation or ownership thereto.

Print Name

Signature Date

ADDITIONAL INFORMATION:

Exclude from following Activities:

INDIAN NATIONS PRESBYTERY
1001 NW 25ffi Street, Suite 206
Oklahoma City, Oklahoma 73106

2013 Youth Ministries Medical Form

MINOR INFORMATION (please print)

Full Name of Minor: _____

Address: _____ City: _____ State: _____Zip: _____

Home Phone: _____ Parent/Guardian Mobile Phone/pager: _____

Sex: _____ Date of Birth: ____ / / _____ Grade: _____School: _____

Parent / Guardian Full Name(s): _____

(Some medical facilities may require a Social Security Number to provide treatment. We will contact you if we need this information)

HEALTH / DENTAL INSURANCE INFORMATION

Health Insurance Company: _____

Policy Number: _____Group Number: _____

Phone Number: _____

Dental Insurance Company: _____

Policy Number: _____Group Number: _____

Phone Number: _____

EMERGENCY CONTACT INFORMATION

In an emergency, please notify one of the following:

Name/Relationship_____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone/Pager: _____

Name/Relationship_____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone/Pager: _____

MEDICAL HISTORY

Has minor had all school-required vaccinations? Yes No Date of last tetanus shot: _____

Does minor have a communicable disease or medical condition that may be a risk to others? Yes No If Yes, .Please describe:

_____

Does Minor have any drug allergies? Yes No If Yes, Please describe: _____

_____

Please list the name, dosage, and purpose of medications currently being taken by Minor: _____

_____

_____

Please describe any special considerations regarding Minor (medical conditions, food allergies, dietary restrictions, activity limitations, behavioral issues/concerns, etc): _____

_____

AUTHORIZATION FOR MEDICAL TREATMENT

As the parent or legal guardian of _____ ("Minor"), each of the undersigned gives his or her authorization and consent for the Indian Nations Presbytery of Oklahoma City, Oklahoma (the "Church") and the Church's adult employees, agents, and volunteers (collectively with the Church, the "Indian Nations Presbytery Parties") to seek, authorize, and consent to such medical or dental care for Minor ("Treatment") as any one or more of them may deem necessary or appropriate. Such Treatment (1) shall be provided upon the advice of and supervision by a physician, surgeon, dentist, or other medical practitioner licensed to practice under the laws of the state or jurisdiction in which such Treatment is sought, and (2) may include, without limitation, X-ray examination; anesthetic; medical, dental, or surgical diagnosis or treatment; and hospital care. This Authorization for Medical Treatment may be photocopy hereof shall be as valid as an original copy.

Each of the undersigned acknowledges and agrees that the Indian Nations Presbytery Parties shall not be legally or financially liable for any bill or expense incurred in, or any cause of action or claim arising from, the provision of any Treatment or the failure to provide or seek any Treatment. In consideration of Minor's participation in one or more events sponsored by the Church, each of the undersigned hereby agrees to indemnify, defend, and hold harmless the Indian Nations Presbytery Parties from and against any and all losses, damages, liabilities, or expenses (including, without limitation, reasonable attorneys' fees and other costs of defense) in connection with any and all actions, suits, claims, or demands that may be brought or instituted against any Indian Nations Presbytery Party and arise out of or result from the provision of any Treatment or the failure to provide or seek any Treatment. This paragraph shall survive any termination or expiration of the Authorization for Medical Treatment for any reason.

Name: * _____ Signature:_____ Date: _____

Name: * _____ Signature: _____ Date: _____

** Note: Each person who has legal custody of Minor should sign this Authorization for Medical Treatment, and only a person who signs will be considered a legal custodian of Minor.*