



New Hope Christian Schools

Education with Eternal Benefits

Member, Association of Christian Schools, Int'l and Oregon Federation of Independent Schools
5961 New Hope Rd, Grants Pass OR 97527 ♦ 541-476-4588 ♦ (fax) 541-474-7626 ♦ nhcs@newhopechristian.net

Medical Release Form

This signed form is required for all student participants to the High School Spiritual Emphasis Retreat. This form should be signed and dated by a parent or guardian in the appropriate spaces and returned to the school by Friday, September 23th, 2011

MEDICAL INFORMATION & CONSENT FORM

_____ is hereby granted permission to participate in the High School Spiritual Emphasis Retreat at Fir Point Bible Camp on September 28-30, 2011.

I, the undersigned, hereby authorize the staff and designated volunteer workers of New Hope Christian Schools as our agents and give consent for medical or surgical treatment by any licensed physician or hospital for my student when such treatment is deemed necessary by such physician and I cannot be reached within a reasonable time. Such consent may include, but is not limited to, administration of necessary anesthetics, medical treatment, tests, x-rays, transfusions, injections, or drugs and their performance of whatever operations may be deemed necessary or advisable. It is understood this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide the authority to consent thereto, as our said agent and my student's attending physician, in the exercise of their best judgment, may deem advisable. This authorization shall remain effective until my student returns home from the activity named above.

My student may:

- take an aspirin substitute for headaches or other minor aches, according to package directions
- take Tums or Pepto-Bismol for stomach irritations, according to package directions
- have a topical ointment (Neosporin) applied to slight cuts or injuries, according to package directions.

(circle one) YES - NO

Please list physical conditions that may affect participation or emergency first aid and treatment:

Medication for allergies: _____

Last tetanus immunization date: _____

(CONTINUED ON THE BACK)

Does your student have hay fever, asthma, or allergies (food, bee stings, etc)? YES - NO

- If yes, specify and list side effects.

Please list any other personal situations that we should be aware of:

Student's Date of Birth: _____

Home Phone: _____

Address: _____

City/ZIP Code: _____

Parent / Guardian names: _____

Work Phone: _____ Cell Phone: _____

Emergency contact person: _____

Phone: _____

Physician name: _____

Phone: _____

Address: _____

City/ZIP Code: _____

Insurance Company: _____

Subscriber name: _____

Policy number: _____

My signature indicates that the above information is correct as supplied and the specific authorizations are approved.

Date: _____

Parent/Guardian Signature: _____