



## MEDICAL & LIABILITY RELEASE / STUDENTS

With the increasing sophistication of our hospital systems, Trout Lake Camps has found it necessary to have a signed parental release form in the unlikely event of a serious injury requiring hospital treatment for your child. This release gives us permission to take your child to the nearest available medical facility and have the necessary medical treatment administered. Many hospitals will not administer any medical attention to a minor without parental consent.

**BIG PICTURE:** I understand and certify that my child's participation in Trout Lake Camps retreat, event, conference, or camp is completely voluntary and I have familiarized myself with camp's program and activities in which I will be participating in. Although Trout has taken safety measures to minimize risk, Trout cannot guarantee that the participants, equipment, premises and/or activities will be free of hazards, accidents and/or injuries. I further recognize the importance of knowing and abiding by Trout rules, regulations, and procedures for the safety of camp participants.

I hereby give Trout Lake Camps, our church leadership, or other emergency medical personnel the permission to act on my behalf in seeking emergency medical treatment for my child in the event that camp or church staff deems such treatment necessary. I give permission to those administering emergency medical treatment to do so using those measures deemed necessary.

I also absolve Converge North Central and Trout Lake Camps and/or its staff personnel from liability in acting on my behalf in this regard so long as they are not grossly negligent.

**TO FULLY UNDERSTAND THE SPECIFIC RISKS ASSOCIATED WITH OUR RETREATS AND ACTIVITIES, READ THE BACK PRIOR TO SIGNING BELOW**

Church Name: \_\_\_\_\_

Name of Child(ren): \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Print Parent/Guardian Name(s): \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

If Parent / Guardian are not available, please call person below:

Name: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Phone #: \_\_\_\_\_

May we administer over-the-counter-medications:  
(ex: aspirin, Tylenol, Advil, antibiotic ointments, etc.)

Yes                      No

Additional comments regarding medical history, allergies, penicillin or drug reactions, use of over-the-counter-medications, etc., which may be needed in treatment:

Signature of Parent / Guardian: \_\_\_\_\_

Date: \_\_\_\_\_