MEDICAL POWER OF ATTORNEY AND RELEASE

WHEREAS, ______________________________ is the dependant of_____________________________ and ____________________________ and WHEREAS, Sparks Christian Fellowship (hereinafter called SCF) has various youth activities throughout the year which said dependant may participate in with our permission and during such time the supervision, care, custody, and control of this dependant shall be with representatives of SCF.

NOW THEREFORE, ___________________________ and ___________________________ parents/guardian of _________________________ do hereby make this statement for the benefit of such dentists, doctors, surgeons, hospitals, medical facilities, or other medical persons or facilities, including their family doctor, who might, from time to time have occasion to treat an illness or other medical problem of _________________________ that said dependant will be under the care, custody and control of SCF. The undersigned appoint any representative of SCF or any trip related personnel as our attorney-in-fact with the power to execute such documentation and releases as may be necessary and to make such decision as may be necessary and in the best interest of said dependant in all areas of health or otherwise, including but not limited to examination, treatment and surgery.

We,________________________ and _______________________, further recognize that youth activities, recreation, and travel by their very nature could include a risk of injury.

THEREFORE, we, ___________________________ and______________________________ agree to hold harmless SCF and its representatives, and other Youth trip leaders, associated groups, personnel, and organizations from any injuries suffered and agree to indemnify SCF and those previously listed from any expense, claims, or liability arising from an injury or death to_______________________; and we agree to have this form become a permanent record for use on any church-related activity. We further recognize that it is our responsibility as parent/legal guardian to update information on this sheet (front and back) as it becomes necessary to do so (medical information, insurance company/policy information, emergency contacts, current medications, and all else on this form (front and back).

THIS STATEMENT is made for the benefit of ________________________'s best interest, and medical facility personnel are entitled to rely upon the representations and statements contained herein.

THIS NOTICE shall remain effective, with necessary changes as they occur, on every church-related activity said dependant participates. The undersigned also understands that photograph(s) or video or audio recording(s) taken of applicant by agents, employees or representatives of SCF, shall be used in connection with SCF's dissemination of information by its public service and academic programs to the general public. The undersigned hereby irrevocably authorize SCF to copy, exhibit, publish or distribute any and all such images and audio of applicant or wherein applicant appears, including composite or artistic forms and all media throughout the world (including print, non-theatrical, home video, CD-ROM, internet and any other electronic medium presently in existence or invented in the future), the right to use and incorporate (alone or together with other materials), in whole or in part, photographs or video footage taken of applicant, for purposes of publicizing SCF programs for any other lawful purpose. In addition, undersigned and applicant waive any right to inspect or approve the finished product, including written copy, wherein the applicants' likeness appears.

As used herein the singular shall include the plural and vice versa.

This statement and the power of attorney set forth herein shall survive my/our disability.

DATED _______ /______ /20_____

____ ____

Parent/Legal Guardian Parent/Legal Guardian

(OVER)

Youth Information

(Please Print Clearly)

Applicant's Name____ Date of Birth ___ /___ /___

Grade ____ School ____________ Phone home______________ Phone cell ______________ T-Shirt Size _____

E-Mail ____

Address ____ City______________ Zip____________

Insurance/Physician Information

If no insurance, write NONE

Health Insurance Company ______________________________ Policy # ____________________

Name of Insured ____________________ Family Doctor ______________ Doctor's Phone ____________

Date of last tetanus shot ___ /___ /___

List any medical problems, special medications, diets, allergies, recent major illness or surgery. ***If none, write None.***

____

List any activity restrictions: ____

Please list all medications your son or daughter will be taking on the trip: ______________________

____

SCF's insurance is secondary insurance. If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury incurred.

Emergency Contacts

Name of Contact/Relation to Applicant	*Phone Number*	*Relation/Place (home, work, cell)*

In the event I cannot be reached in an emergency, I hereby give my permission to the physician or dentist selected by the SCF representative to Hospitalize, secure proper treatment, and/or order an injection, anesthesia, or surgery for my child as deemed necessary.

____

Parent/Legal Guardian Signature

THE FOLLOWING CHANGES ARE MADE TO THIS FORM ACCORDING TO DATE LISTED

____ Date ______________________

____ Date ______________________