CITYREACH

**CityReach Medical and Media Authorization**

Name:_____ Age:____ Grade:____ Male Female
Address:_____
City:_____ State:____ Zip:_____

Leader's Name:_____ Pastor's Name:_____
Attending Church Name:_____

In case of emergency, notify:
Name of Parent / Guardian:_____
Address:_____
City:_____ State:____ Zip:_____
Primary Phone:_____ Circle one: Home / Cell / Work
Secondary Phone:_____ Circle one: Home / Cell / Work

Secondary emergency contact:
Name:_____ Relation:_____
Address:_____
City:_____ State:____ Zip:_____
Primary Phone:_____ Circle one: Home / Cell / Work
Secondary Phone:_____ Circle one: Home / Cell / Work

Will the camper be taking medication while at CityReach? Yes No
Medicine:_____ Dosage:_____ Time of Day:_____
Medicine:_____ Dosage:_____ Time of Day:_____

**Permission to administer (check all that apply):**
__Tylenol __Ibuprofen __Benadryl __Antacids __Cold Medication __Antibiotic Cream

**Major medical history (check all that apply):**
__Asthma __Diabetes __Kidney Trouble Heart Condition:_____
__Dizziness __Bronchitis __Sinusitis __Concussion
Other:_____

**Please list any allergies:**

Has CityReacher recently been under a doctor's care? (explain):

**Consent for Medical Treatment and Media Release**

I give full permission for the above to attend CityReach and to take part in all activities. My child will not attend if he/she has been exposed to a contagious disease of if he/she is not in good physical condition. I do not hold CityReach Personnel and/or Sponsors responsible or any accident or illness; and if necessary, authorize CityReach Personnel and/or Sponsors to take my child to a physician or hospital. I also give my full consent for the doctor selected to render professional services to my child, if he/she becomes ill or is involved in an accident. As a parent/ legal guardian, I give my permission for the above to be photographed and/or filmed during CityReach for the purpose of publications, multimedia, or website.

**Charges for Insurance**

Company Name:_____
Policy Number:_____ Address:_____
City:_____ State: ____ Zip:_____
Phone:_____
Have doctor bill me:
Company Name:_____
Address:_____
City:_____ State:____ Zip:_____

_____ _____
Parent/Guardian Signature Date