*College Hill Lutheran Church & Brammer Student Center*
*2322 Olive Street*
*Cedar Falls, IA 50613*
*319-266-1274*

# HIGH SCHOOL WEEKEND 2017

## REGISTRATION

Name: ___________________________________ Home Church: _____________________________________

Address: ________________________________________________________________________________________

________________________________________________________________________________________

Phone: ___________________________________

Emergency Contact: ___________________________________________________________________________

## RELEASE OF ALL CLAIMS & PERMISSION TO TREAT

In consideration for being accepted by College Hill Lutheran Church and Student Center, Cedar Falls, Iowa, for participation in the High School Weekend on January 14-15, 2017, I (we) as parent(s) do hereby release, forever discharge and agree to forever hold harmless College Hill Lutheran Church and Brammer Student Center, Cedar Falls, Iowa, the directors, officers, employees and agents thereof, from any and all liability, claims and demands for personal injury, sickness and death, as well as property damage and expenses, of any nature whatsoever which may be incurred by our student that occur while said person is participating in the above described High School Weekend, which shall include travel to and from Cedar Falls, Iowa and the event and time spent at the event.

Further, authorization and permission is hereby given to said organizations to furnish any transportation, food, and lodging for this participant.

Further, authorization and permission is hereby given to said organizations to seek medical treatment for this participant if need should arise. Given below is all the pertinent medical information.

Parent's Name: _________________________________________________

Parent's Signature: ______________________________________________ Date: ____________________

Parents' Home Phone: ____________________________________________________________________________

Complete both sides of this form.

All information is confidential.

# CHLC High School Event Health Form

First Name ________________________________Last Name ____________________________________

Birthday ___ / ___ / ___ Age ____ Grade this Fall _______ Gender ____________

Address ________________________________________ Information Provided By: _____________________

City _________________________ State _____ Zip _________ Home Phone ___________________________

Parent 1 First Name _____________ Last Name __________________ Cell ____________ Work _____________

Parent 2 First Name _____________ Last Name __________________ Cell_____________ Work ____________

**IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:**

Name _________________________ Relationship _____________ Phone _____________ Cell ____________

Doctor _____________________________________________________ Phone _______________________

Dentist _____________________________________________________ Phone _______________________

Pharmacy ___________________________________________________ Phone _______________________

**NAME OF FAMILY MEDICAL/HOSPITAL INSURANCE:**

Insurance Carrier ______________________________________ Policy # ______________________________

Insurance Phone Number To Call (if applicable) ________________________

Primary Insured's Name ___________________________________________

Activity Restrictions by parent's/physician's advice?:______________________________________________

___________________________________________________________________________________

Other information we need to know?_______________________________________________________

**ALLERGIES:** ❑ Hay Fever ❑ Poison Ivy ❑ Insect Stings

❑ Food: _______________________________ ❑ Peanut Butter ❑ Nuts

❑ Asthma ❑ Penicillin ❑ Other Drugs: __________________________________________

Medications Brought To Event: __________________________________________________________

Notes on Giving: ____________________________________________________________________

Acetaminophen, Ibuprofen, antacids, anti-diarrhea medication and first aid **MAY / MAY NOT (CIRCLE ONE)** be administered to my child, as needed, by designated chaperones.

Special Considerations? _________________________________________________________________

**AUTHORIZATIONS:**

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed event activities except as noted above. I also give permission to the event coordinator or chaperone to order x-rays, routine tests and treatment. In the event I cannot be reached in an emergency, I give permission to the physician selected by the event coordinator to transport, hospitalize and secure proper treatment, order injection and/or anesthesia and/or surgery.

Signature of Parent/Guardian ____________________________________________________________

Date ______________________________

**(THIS FORM MUST BE COMPLETED, SIGNED AND BROUGHT WITH PARTICIPANT TO REGISTRATION.)**