HESED

MEDICAL RELEASE FORM

_____will attend/ participate in HESED on _____ (date) at Camp Royall.

Choose One:

_____is not able to administer his/her own medication; please provide supervision or reminders.

_____is able to administer his/her own medication and requires no supervision or reminders.

I___ am the parent/guardian **(or** ___I am my own guardian**)** and will not hold Eastern North Carolina Lutheran Via de Cristo, Presbyterian Pilgrimage, the team for the Hesed retreat, or Camp Royall responsible for any accident or injury that I / he/she might sustain.
I also give permission in my absence to any medical staff to perform emergency medical treatment needed.

My family physician is _____ phone_____

During the Hesed Weekend, If there is an emergency, the person(s) to call is

_____ at PHONE: (Home) _____ (Cell)_____
(name) (give weekend / emergency phone number please)
OR
_____ at PHONE: (Home) _____ (Cell)_____
(name) (give weekend / emergency phone number please)

Your signature _____
Print your name _____ Date: _____
Address and telephone number (of guardian; if different from the participant's)

_____
_____ Phone: _____
Relationship (to participant) _____

****VERY IMPORTANT – Please include a copy of your insurance card and write the name of the facility(s) in which this insurance is accepted in the space below. Thank you.

Please list all the prescription medications he/she takes:

Name of Drug	Strength	Amount	How Often	Mode of Dispensing (use key below)	Reason	Special instructions (i.e.;mix w/food; take on empty stomach, etc)

KEY-(use the following codes to describe each medication) :

P (pill)
INJ (injection)—subQ (into fat) or IM (into muscle)
SubLing (under tongue)
Topical (on skin); indicate what part of the body
Eye Drops --(indicate right or left)
Ear Drops -- (indicate right or left)

Please mail this form together with the Guest Application or with the Team Application. The address is on those forms.