

**LONG ISLAND YOUTH FOR CHRIST**  
**PERMISSION SLIP / WAIVER AND INDEMNITY AGREEMENT & AUTHORIZATION FOR MEDICAL TREATMENT FORM**

Name of Participant: \_\_\_\_\_  
*(Please print)*

For: SUMMER ESCAPE- Campus Life 2 Summer Camp Date: August 6- 11, 2006

Located at: Rock Mountain Bible Camp- South Gibson, PA

In consideration of your accepting me or my child for participation in the above named program, activity or sport, I hereby, for myself, my heirs, executor and administrators, waive and release any and all rights and claims for damages that I may have against the above named organization and its agents, employees, representatives, successors and assigns for any and all injuries suffered by myself or my child that arise out of the above named program, activity, or sport sponsored by the above named organization.

I warrant that I have the right to authorize the foregoing and do hereby agree to hold the above-named organization harmless of and from any and all liability of whatever nature, which may arise out of or result from such participation.

For the consideration stated above, I further agree that in the event that my child or I should make any claim against the above-named program, activity or sport, I will personally indemnify, defend or hold harmless the organization and its agents, employees, representatives, successors and assigns against any and all loss and damage occasioned thereby, including attorney's fees.

I have read and understand this Agreement and have willingly placed my signature below as evidence of acceptance of all the conditions contained herein.

**Authorization for Medical Treatment**

This release and consent give Long Island Youth for Christ (LIYFC) permission to take my child to the nearest available medical facility and have any necessary emergency treatment administered.

I understand that every effort will be made to contact me. However, in case of emergency, if I cannot be reached, I hereby give LIYFC permission to act on my behalf in seeking medical treatment by qualified personnel for my child in the event that such treatment is deemed necessary or advisable for my child's health, safety and welfare. I release LIYFC and all medical providers from liability in acting on my behalf in this regard rendering such medical treatment.

**Note: I understand that my personal insurance is primary. I have read and understand this agreement.**

**Current Medical Condition**

List **any and all** medical conditions, allergies, or medical limitations that your child may be experiencing or has experienced in the past.

\_\_\_\_\_  
\_\_\_\_\_

Birth day \_\_\_\_\_ Date of Last Tetanus Shot: \_\_\_\_\_

**Current Medications** (Medications must be sent with participant in their original containers.)

<u>Medication name</u>	<u>For</u>	<u>Dosage</u>
_____	_____	_____
_____	_____	_____

Health Insurance Co.: \_\_\_\_\_ Group No.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured under who's name: \_\_\_\_\_ S.S.# of insured: \_\_\_\_\_

Participant's Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

**In an emergency, you may call the person listed below in the event that a parent cannot be reached.**

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

**SIGNATURES**

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

Parent/ Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Print Parent/Guardian Names: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

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