**FORM 9 – DUE 1 MONTH BEFORE TRIP:**

**MINOR Dayspring Camp & Conference Center, Inc. (DCCC) RELEASE FORM (0-17 years)**
**Participant:** Please complete ALL information requested, give completed form to your team leader.

**Team Leader**: Please review and sign each form; send copy to DCCC and take original to the project.

Participant's name: Project location: Fairmont, WV

Date of birth *(mm/dd/yyyy*): Project dates:

Gender (male/female): Church name:

Address: Church city/state:

City, state, zip: Team leader:

Emergency contact name and phone (must not be a trip participant):

**PROJECT INSURANCE COVERAGE AND REQUIREMENTS**

1. **What we require:**

**Each participant is required to have his/her own primary emergency** medical coverage. Any participant, who does not have a primary medical insurance policy, must apply for supplemental coverage. Recommendations for supplemental coverage are available from Dayspring leadership.

1. **Please indicate the status of your primary medical insurance:**
* I do have a primary medical insurance policy. **Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* I do not have a primary medical insurance. I am applying for supplementary coverage for my child.

**PARENTAL PERMISSION TO TRAVEL AND RELEASE OF LIABILITY**

**Both parents must sign this section. If a parent is deceased or divorced, please indicate so in writing.**

As a parent or guardian, I give my permission for my child (name) to travel to Fairmont, WV to participate in DCCC’s Impact WV Program on the following dates: . I am aware of the inherent risks and dangers to my child in traveling to and visiting other states and the potential risks to my child and his/her property as a result of participation in DCCC’s Impact WV project (including but not limited to illness, injury, acts of terrorism, death, robbery, kidnapping, or other loss or destruction of life or property). I fully assume these risks, understanding that DCCC cannot be responsible for any personal loss or disaster that my child may experience in connection with his/her volunteer ministry service to DCCC. I hereby agree to waive and release any and all claims and causes of action for damages or other relief that I may have against **DCCC, Mission to North America, the Presbyterian Church in America, my sending organization, or any of their affiliated or member entities**, **and their respective officers, directors, employees, agents, attorneys, or representatives, based on my child’s volunteer services for DCCC.** I acknowledge personal responsibility for my child’s actions outside the direction of ministry personnel, or the scope of this ministry project or program. I understand that this release of liability is effective only as it applies to, and as interpreted by the laws of the countries involved.

**Signature of father:**  **Date:**

**Print name:** **Email:**  **Phone:**

**Signature of mother:**  **Date:**

**Print name:** **Email:**  **Phone:**

**Other legal guardian:** **Relationship:**  **Date:**

**Print name:** **Email:**  **Phone:**

**MINOR DCCC RELEASE FORM**

##### Medical history: As a project participant, you are asked to give the following health information, in order for the project administrators to be aware of any risk your participation may create. Failure to provide known information will release both the team leader, DCCC, and project managers/staff from responsibility arising due to complications brought on by the activities of this project.

1. **Please check any conditions for which you have been treated or seen a physician.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Heart Trouble |   | Kidney Stone or Infection |   | Digestive / Intestinal Disorder |  |
|  |  | Heart Murmur |   | Bladder Stone or Infection |   | Colitis |  |
|  |  | Abnormal Pulse |   | Gall Bladder Disease |   | Ulcer |  |
|  |  | Rheumatic Fever |   | Internal Bleeding |   | Gout |  |
|  |  | Chest Pain |   | Prostate Trouble |   | Deformity / Amputation |  |
|  |  | Stroke |   | Sugar, Albumin, Blood or Pus in Urine |   | Skin Disorder |  |
|  |  | High Blood Pressure |   | Psychiatric Problem |   | Hernia |  |
|  |  | Hardening of the Arteries |   | Emotional/Nervous Problem |   | Disease of Eyes |  |
|  |  | Diabetes |   | Epilepsy / Convulsion |   | Disease of Ears |  |
|  |  | Circulatory Disorder |   | Other Nervous System Disorder |   | Disease of the Nose / Throat |  |
|  |  | Blood Disorder/Disease |   | Cancer / Tumor |   | Bronchitis |  |
|  |  | Hepatitis |   | Dizziness / Loss of Consciousness |   | Tuberculosis |  |
|  |  | Anemia |   | Frequent Headaches |   | Other Lung Disorder |  |
|  |  | Thyroid/other Gland Problem |   | Arthritis |   | **Asthma\*** |  |
|  |  | Cirrhosis / Liver Trouble |   | Sciatica |   | **Allergy\*\*** |  |
|  |  | **Pregnant** (currently): *Pregnant women are not permitted to participate on projects rated as Intermediate, substantial or high risk. Check with your Project Administrator if you are not sure of your project rating.* |  |

1. **Are you currently being treated for any of the above conditions?** ○ **Yes** ○ **No**

If yes, please list the condition and the date of most recent treatment/doctor’s visit:

**Are you currently taking any prescription medications?** ○ **Yes** ○ **No**

If yes, please list the names of the medications:

1. **Please list all allergies, including food and medications:**

 *Note: If you have an allergy that requires an EpiPen or other treatment, please bring the appropriate medication with*

 *you.*

1. **Do you have any other special needs we should be aware of?**

**IMMUNIZATIONS**

1. My child has had all routine immunizations *(dT-diphtheria, MMR-measles, mumps, rubella, and polio)*.

○ Yes ○ No

1. My child has had a tetanus booster within the past 10 years.
○ Yes  ○ No,but he/she will have by the beginning of the project. ○ No, my child is allergic to tetanus shots.
2. My child has had the COVID vaccinations (not required), ○ Yes ○ No

**MEDICAL CONSENT: Both parents must sign this section. *(If a parent is deceased or divorced, please indicate so in writing****.)*

**In the event of a medical emergency**, I hereby consent to the necessary and proper treatment, surgery, and/or anesthetic by a licensed physician or health care professional for my child *(name)* .

**Signature of father:**  **Date:**

**Signature of mother:**  **Date:**

**Other legal guardian:** **Relationship:**  **Date:**

 **Signature of team leader:**  **Date:**