Medical Release Form/Parent Information
For Team Members Under 18

TO BE COMPLETED BY PARENT OR GUARDIAN
MUST BE COMPLETED BEFORE WEEKEND
GIVE TO HEAD CHA

Team Member's Name____

Address: ________________________City: ____________________________ State___ Zip_________

Telephone Number (include area code): ____

Central Georgia Vida Nueva would like to inform you of some of the responsibilities that will be asked of your child during the preparation and execution of a VN weekend:

1. Pay a weekend fee of $85.00 for food and lodging to be due before the weekend and attend at least half of the team meetings.
2. Have a signed copy of this Medical Release form (required for campground).
3. Participate in the cleaning of the campground with their section head prior to the weekend and before closing on Sunday of the weekend.
4. Be at the campground by 4:00 p.m. on the Friday of the weekend.
5. Bring two (2) 2-liter drinks and any food your child has signed up to bring.
6. Make sure that they have all personal items needed from the list in their team book, such as bedding, toiletries, medications, clothing, etc.
7. Fulfill any other duties or obligations required for their position on the weekend.
8. Have a Christ-like attitude as well as a servant's heart.

**Should your child have to drop from the team please have them notify the director as soon as possible so a replacement can be made in a timely manner.

***Should your child be unable to fulfill his/her responsibilities due to illness or other circumstances during the weekend, you as the parent/guardian will be called and arrangements will be made accordingly.

Furthermore, by signing below I do hereby release Vida Nueva of Central Georgia and its staff and sponsors from responsibility and liability for any injury or illness that my child as named above may sustain during any and all activities in which he/she may participate during the dates of the Vida Nueva weekend in which they are participating.

In the event of an emergency, I do hereby authorize an adult leader as agent for me, to consent to any X-ray exam, medical, dental, or surgical diagnose, treatment and hospital care advised by a Physician, Surgeon, or Dentist, as appropriate, licensed to practice under the laws of the state where the services are rendered, either at a doctor's office, hospital, or any other medical care facility.

Parent or Guardian’s Name____

Emergency Telephone Number (include area code) ________________________

Medical Insurance Company____

Policy Number_____________________

Signature of Parent or Guardian____

Please list any medical allergies, medications being taken, medical problems, special diets, or other pertinent information:

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