

Trinity Lutheran Church
320 SE Fir Villa Rd.
Dallas, OR 97338
503-623-2233

High School Mission Trip Medical Release Form

The undersigned parent or guardian of _____ hereby authorize Trinity Lutheran Church, Dallas, OR, in the event of an emergency, to consent to and authorize all medical, dental and optical care and hospitalization that this young person may require. This authorization is made pursuant to ORS 126.030(1). I agree to pay and be responsible for all costs incurred by reason of such care.

This authorization is given for the Youth Group Mission Trip activities conducted by Trinity Lutheran Church, both on/off site.

I hereby release and discharge the Evangelical Lutheran Church in America, Trinity Lutheran Church, its staff and any sponsors or representatives of the foregoing from any and all claims or liabilities that may arise in connection with these activities and with the exercise of the authority given herein.

Dated: _____

Printed name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Contact Information

Address: _____

Home phone #: _____ Cell #: _____ Text?(Y/N) _____

If parents cannot be reached, please contact:

Name: _____ Phone #: _____

Medical Information

Family physician: _____ Phone #: _____

Insurance company: _____

Policy #: _____

Special concerns: _____

Current medications: _____

Is immunization current? ____ Yes ____ No

If 'no', please explain: _____

I do not give permission for photographs of my son or daughter to be used in Trinity's church or Mission Trip publications.