PRUDE RANCH
PERMISSION/MEDICAL AUTHORIZATION/LIABILITY RELEASE FORM

PARTICIPANT'S NAME: ____ **Sex:** _______ **Date of Birth:** ___/___/______

To Parent or Guardian: This permission form must be filled out completely and returned to your child's sponsor in order for your child to attend activities at Prude Ranch/Tres Rios Youth Connection 2012 with the Tres Rios Presbytery. No child will be permitted at the ranch without this form, completed and signed.

I, ______________________________ (please print), the Parent/Guardian of the above named participant, do hereby release Prude Ranch, Tres Rios Presbytery and/or the Sponsors of the trip and/or function from any and all liability in the event of sickness or injury during the duration of the Tres Rios Youth Connection, 2012. I further understand and acknowledge that certain activities such as horseback riding, swimming, and hiking have an increased risk of injury.

I certify that my child is in good health and can participate in all normal activities of the group.

I understand that my child will leave from ____________________________(location) on _____________(day), _______________(date), will travel to Prude Ranch in Fort Davis, Texas, spend ________ nights at Prude Ranch and return to the above location by _____________(time) on _____________(day), ______________(date).

In conjunction herewith, I grant to Prude Ranch, Tres Rios Presbytery and/or the Sponsors of the trip, or each of them, the power to authorize any and all medical treatment deemed necessary for my child to include but not be limited to the authorization by said Sponsor(s) to the physician of his/her choice for any treatment necessary, to any hospitalization deemed necessary, and the power to authorize any procedures necessary to the care of said child to include, but not be limited to any surgical and/or anesthesia procedures. I authorize for a doctor to be called and/or other medical services to be provided, at my expense, should an emergency arise.

____ ________________________

Parent/Guardian Signature Date

MEDICAL INFORMATION

MEDICAL CONDITION(S) (ist chronic conditions, for example, sinus, kidney problems, asthma, diabetes, etc):
continue on reverse if needed

____

ALLERGIES (list any foods, insect bites, medicines, etc.)
continue on reverse if needed

____

FAMILY PHYSICIAN: ____ PHONE: ______________________

MEDICAL INSURANCE: ____ POLICY NUMBER: ______________________

INSURANCE PHONE: ____________________________ HOLDER'S NAME: ______________________________

CONTACT INFORMATION

PARENT OR GUARDIAN NAME: ____________________________ BEST CONTACT PHONE #: ______________ ALTERNATE PHONE # ______________

PARENT OR GUARDIAN NAME: ____________________________ BEST CONTACT PHONE #: ______________ ALTERNATE PHONE # ______________

ADDRESS: ____

In case or emergency, and the child's parent/guardian(s) cannot be reached,

CONTACT: ____________________________________, **PHONE:** _________________________