ORCHARD
COMMUNITY.CHURCH

Orchard Student Ministries Consent and Medical Release Form

This form is required for students to participate in any off campus event.

To Whom It May Concern: I (parents/guardians name) _____, parent or guardian of (students name) _____ do hereby allow the named child to attend and participate in the activities and events of Orchard Community Church during the year 2018. I agree and consent to have the staff members, leaders and/or counselors, under whose auspices the program is conducted, and any other worker in the program approved as parent to secure any emergency medical care or treatment that may be necessary for my child during these activities, including transportation to and from any and all destinations. I further assume all responsibility for the decisions so made, and the emergency care or treatment so secured by and/or for my child. Should I, the participant, be 18 years of age or older, I hereby agree to all of the above concerning myself.

I being 18 years of age or older, do for myself (and on behalf of my child, if said child is not 18 years of age or older), hereby release, forever discharge and agree to hold harmless Orchard Community Church and the directors thereof, from any liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever, which may be incurred by the undersigned and/or the child and/or that may occur while said child is participating in any youth group activity.

Furthermore, I (and on behalf of my child if under the age of 18 years) hereby assume all risk of personal injury, sickness, death, or damage as a result of participation in any activities involved therein.

The undersigned further hereby agree to indemnify said church, its directors, employees and agents, for any liability sustained by said church as the result of the negligent, willful or intentional acts of said participant.

I am the parent or legal guardian of this participant, and hereby grant my permission for him/her to participate fully in the activities of Alive Student Ministries of Orchard Community Church, and hereby give my permission to take said participant to a doctor or hospital and hereby authorize medical treatment, and assume the responsibility of all medical bills, if any. Further, should it be necessary for the participant to return home due to disciplinary action, for medical or otherwise, I hereby assume all transportation costs.

Participant's signature_____, Participant's Birth date_____, Age____, Grade____

Parent/Guardian Signature _____ Relationship to participant_____

Home Address _____

Telephone (daytime) _____ (Evening) _____ (Cell) _____

Emergency contact (name) _____ Telephone _____

Do you carry medical/hospital insurance?_____ (If yes, continue below. If no, leave below blank.)

Name of insurance company _____ Policy or group # _____

Does the participant have any medical condition(s) / allergies that any medical professional or we should be aware of? If so, please list them here: (continue on back if necessary) _____

_____

_____

PONDEROSA

Physical Form

Return to Group Leader so he/she can have to Ponderosa by June 2nd—No Exceptions!

15235 Furrow Rd - Larkspur, CO 80118
Email: TRawls@VisitPonderosa.com
Fax: 719-481-6402

The COLORADO DEPARTMENT OF HUMAN SERVICES DIVISION OF CHILDCARE mandates that the camper's parent/guardian provide a health history to Ponderosa as well as a statement confirming a physical examination has been performed ***within the preceding 18 months*** by a licensed physician or a qualified, licensed nurse practitioner demonstrating that the camper is capable of attending camp.

Camper Name: _____

Church Name: _____

Dates Attending Camp: _____

TO BE COMPLETED BY A PHYSICIAN/CNP

Medical conditions Ponderosa should be aware of (Should be same information entered in online registration):

_____

_____

List any serious illnesses or operations and dates: _____

_____

_____

Special instructions (e.g. dietary restrictions, exempted activities, etc.) _____

_____

_____

Allergies (i.e. drugs, food, other): _____

_____

_____

_____ was given a physical examination on _____/_____/_____.

(Must be within 18 months of designated camp) Camper is in satisfactory physical condition and capable of active participation in a camp program AT HIGH ALTITUDE, except as noted above.

Signature of Doctor _____ **Date** _____

Printed Name _____ **Phone (_____)**_____

Address_____**City**_____**State**_____**Zip**_____

PONDEROSA

Medication Form

Due 2 weeks before camp (no exceptions)

15235 Furrow Rd., Larkspur, CO 80118
Email: kpeck@visitponderosa.com
Fax: 719-481-6402

Dates Attending Camp _____

Church Registered With _____

Camper Name _____

Ponderosa agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication. **Prescription medications** must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication (OTC) OTC medications are stocked at Ponderosa and used to manage common illness or injuries. These medications are dispensed by licensed health personnel. We must receive a signature from a doctor or CPN authorizing the dispensing of these medications.

The parent/guardian of _____ (Child's name) ask that the licensed health personnel at Ponderosa give the medication/s listed below by our Health Care Provider to my child, according to the Health Care Provider's signed instructions.

By signing this document, I give permission for my child's health care provider to share information about the administration of my child's medication with the licensed health personnel at Ponderosa, delegated to administer medication.

_____ Parent/Legal Guardian's Name

_____ Parent/Legal Guardian Signature

_____ Date

_____ Work Phone

_____ Home/Cell Phone

Health Care Provider Authorization to Administer Prescription and OTC Medication at Ponderosa

Child's Name: _____ Birthdate: _____

Medication: _____ Dosage: _____ Route: _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____ Ending Date: _____

_____ Signature of Health Care Provider with Prescriptive Authority

_____ License Number

Phone Number _____ Date _____

Health Care Provider Authorization to Administer Prescription and OTC Medication at Ponderosa

Child's Name: _____ Birthdate: _____

Medication: _____ Dosage: _____ Route: _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____ Ending Date: _____

_____ Signature of Health Care Provider with Prescriptive Authority

_____ License Number

Phone Number _____ Date _____

Please use additional forms if necessary

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name _____ **Date of Birth** _____

Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)						
DT	Diphtheria, Tetanus (pediatric)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus influenzae* type b						
IPV/OPV	Polio						
PCV	Pneumococcal Conjugate						
MMR	Measles, Mumps, Rubella						
Measles	Measles						
Mumps	Mumps						
Rubella	Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date		Lab Verification Date	
Vaccines recorded below this line are recommended. Recording of dates is encouraged.							
HPV	Human Papillomavirus						
Rota	Rotavirus						
MCV4/MPSV4	Meningococcal						
Hep A	Hepatitis A						
TIV/LAIV	Influenza						
Other							

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ **A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature _____ Date _____

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed _____ Title _____ Date _____
(Physician, nurse, or school health authority)

Name _____ **Date of Birth** _____

Parent/Guardian _____

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW
(DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.

SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

Medical exemption *to the following vaccine(s):*

La exención por razones médicas *aplica a la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____
Physician (Médico)

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

Religious exemption *to the following vaccine(s):*

Exención por motivos religiosos *de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

Personal exemption *to the following vaccine(s):*

Exención por creencias personales *de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)