One Call 2024 Consent-Liability Waiver

"A Living Hope" June 25 – June 29, 2024

Saint John's University

For participants under the age of 18

Participants Name: _____ Birth Date: _____

Parent/Guardian Name(s): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell/Daytime Phone: _____

In the event of an emergency, if you are unable to reach me (us) at the above numbers, contact:

Name: _____ Relationship: _____

Cell/Work Phone: _____ Home Phone: _____

CONSENT:

I (we) give consent for (name of participant) _____ to participate in One Call during the dates listed above. By granting permission, I waive any claims against, and realize and hold harmless One Call Institute and Saint John's University, and their employees and volunteers, from any harm that occurs to my child while participating in this event.

In the event my child requires medical treatment or transportation for medical care, One Call Institute will attempt to contacts me at the number(s) listed above. If they are unable to reach me, they may contact the designated emergency contact at the number(s) listed above. If the staff are unable to contact the designated emergency contact, I authorize them to take appropriate measures to provide care and treatment for my child, to transport my child to the nearest emergency room or physician office, or to call an emergency paramedic ambulance service.

Parent(s)/Guardian(s) signature: _____*Date:*_____

PHOTO RELEASE:

I (we) grant permission for (name of participant) _____ to be photographed/videotaped by One Call, its staff or volunteers. I grant One Call the right to use such photographs or videos in all forms and all manners, for advertising, trade or any other lawful purposes, and I waive any right to inspect or approve the finished version(s), including written copy that may be created and appear in connection therewith.

Parent(s)/Guardian(s) signature: _____*Date:*_____

One Call 2024 Health Information

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Saint John's University

For participants under the age of 18

Participants Name: _____ Birth Date: _____

Name of Physician: _____ Phone: _____

Clinic Name: _____Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

SPECIFIC MEDICAL INFORMATION: One Call will take reasonable care to see that the following information is held in confidence.

- Allergic reactions (medications, food, plants, insects, etc.): _____

  _____
- Date of last tetanus/diphtheria immunization: _____
- Medications participant is currently taking: _____

  _____
- Does participant have medically prescribed diet? _____

  _____
- Any physical limitations? _____

  _____
- Please list all medical conditions/needs (if any) of this participant: _____

  _____

  _____

  _____

I (we) _____, hereby grand permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given if deemed advisable.

Parent(s)/Guardian(s) signature: _____