

Student Information & Medical Authorization

Mission, Ministry, and Service Trips

The information provided in this document is accurate to the best of my knowledge. I understand that I am participating in a service/mission/ministry trip and will adhere to the policies and guidelines set forth by SOTV. SOTV staff and volunteer leaders are not liable for any accidents, injury, delay, damages, transportation systems, or equipment, theft, vandalism, personal items of travelers, weather conditions, or any other unforeseen circumstances. SOTV will treat this document as private and confidential. I understand the information may be used as deemed appropriate to provide assistance during travel. This document will be destroyed upon return and will not be reused for any future trip. Signature on page two with Authorization for Emergency Medical Care Statement.

Participant Name:			
Last	F	First	
Participant Address:			
Street	City	State	Zip
Participant Date of Birth:////	Hair Color:	Eye Color:	
Parent/Guardian Information: (Skip	if you are 18 years o	f age or older)	
Printed Name:	Prir	Primary Phone Number:	
Printed Name:	ed Name: Primary Phone Number:		
Emergency Contact Information: Contravel and destroyed upon return. Please Printed Name:	ase provide any upda	ated emergency contact	s here.
Printed Name:	Prir	nary Phone Number:	
Health Insurance and Medical Inforcarried during travel and destroyed up Permission to Administer: Check al	oon return.		
☐ Acetaminophen ☐ Ibuprofen ☐	☐ Over The Counter	(OTC) Motion Sickness	Medication
□ Over The Counter (OTC) Antihistan	nine		
Current medications you will bring medications must be in original labele	-	st carry and self-adminis	ster. Prescription
Medication	Dosage	Fr	equency



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Medical Information Continued:
Are immunizations current □ Yes □ No Date of last Tetanus:
Medical History:
Please list any known allergies:
Please list any current injuries affecting the participant's abilities on this trip:
Authorization for Emergency Medical Care to a Minor I/We the undersigned parents or legal guardian(s) of the minor child listed on this form do hereby authorize any necessary examination, anesthetic, dental, medical, or surgical diagnosis or treatment by any duly licensed medical personnel and/or hospital and/or medical service provider for the care and treatment of listed minor child. Shepherd of the Valley Lutheran Church and designated group representatives including staff and volunteer leaders are the temporary custodians of the listed minor child. I/We authorize the use of best judgement in treating the minor child and recognize best efforts will be made to contact us for notification and consultation with time that is allowed in any given emergency situation. My/Our permission is granted if I/we cannot be reached to move forward with necessary treatment in the best interest of the minor child. One parent / legal guardian signature is required: Printed name(s) and phone number(s) on page one.
Signature / / Date MM/DD/YYYY