

2019 LCMS LIFE CONFERENCE

JOY:FULLY ALIVE > BODY&SOUL

JAN. 17-19, 2019 - WESTIN ARLINGTON GATEWAY HOTEL - ARLINGTON, VA

Parents and Guardians:

Thank you for allowing your child to participate in the LCMS Life Conference. We look forward to our time together in God's Word learning about what He has done for us. We hope that your youth will learn more about the Christian faith and grow deeper in their trust of Jesus Christ.

In this packet:

1. **Permission for Participation** (See below) — This page *must* be signed and returned **no later than January 1, 2019** to:
LCMS Life Ministry
c/o Barb Temples
1333 S. Kirkwood Road
St. Louis, MO 63122-7295
2. **Medical Consent and Liability Release Form** — This form should be completed and kept in the possession of the congregational adult leader. Your congregation may use a different, standard form to communicate this information. (2 pages)
3. **Consent and Release Form** — This form should be completed and kept in the possession of the congregational adult leader. (1 page)
4. **Authorization to Consent to Medical and Dental Care** — This form should be completed and kept in possession of the congregational adult leader. (1 page)
5. **Emergency Medical Information Form** — This form should be completed and kept in the possession of the congregational adult leader. Your congregation may use a different, standard form to communicate this information. (2 pages)
6. **Parental Information Sheet** — This sheet is for you to keep with your information records. (1 page)

God bless you in your important role of parents and guardians,

LCMS Life Conference
lcms.org/lifeconference

I give my permission and encourage my child to participate in all the activities listed for this event. I also give permission for any media images that may be taken of my child at this event to be used by (church and sponsoring organization) as they see fit.

Name of Youth: _____

(Parent/Guardian Signature)

(Date)

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Medical Consent and Liability Release Form

This form must be completed and carried by all participants and a copy given to group leader.
This form must be signed by parent/guardian of participants under 18.

Please type or print in ink.

Participant Name: (Last) _____ (First) _____

Birth Date: ____/____/____ Male: Female:

Home Address: _____

City/State/Zip: _____

Home Phone: (____) _____ Day Phone: (____) _____

Custodial Parent/Guardian: _____

Home Phone: (____) _____ Day Phone: (____) _____

Health Plan Carrier: _____

Name of Insured: _____ Relationship to Participant: _____

Policyholder/Insurance Id#: _____

Family Doctor: _____

Office Phone: (____) _____ Medical Exchange: (____) _____

Family Dentist: _____ Office Phone: (____) _____

Second Parent or Emergency Contact: _____

Relationship to Participant: _____

Home Phone: (____) _____ Day Phone: (____) _____

Please specify if any health insurance pre-certification, notification, or other requirements exist for the health participant.

Please copy front and back of participant's/cardholder's insurance card in the space below:

(Medical Card Copy Front)

(Medical Card Copy Back)

Consent and Release Form (continued)

I understand that the LCMS Life Conference 2019 for which this Medical Consent and Liability and Activity Release Form is being given is described as follows:

A national event of The Lutheran Church—Missouri Synod for adults and youth held in Washington, D.C. January 17-19, 2019. The event includes the annual March for Life, general sessions, smaller sessions for youth and adults, and fellowship.

I hereby consent to participation of myself (or of my child) in the above-described event. I am aware that in addition to activities such as those listed above, the participant may be involved in other activities such as sightseeing, using public transportation, and meal functions.

I understand that I have a duty to provide primary accident and medical insurance for myself (or for my child) and I declare that I am (or my child is) covered by primary accident and medical insurance.

I RELEASE AND FOREVER DISCHARGE THE LUTHERAN CHURCH—MISSOURI SYNOD, OFFICE OF NATIONAL MISSION/LIFE MINISTRY, WESTIN ARLINGTON GATEWAY HOTEL—ARLINGTON, VA, AND _____ (NAME OF HOME CONGREGATION), THEIR AGENTS AND SERVANTS, SUCCESSORS AND ASSIGNS, DIRECTORS, TRUSTEES, OFFICERS, EMPLOYEES, AND OTHER REPRESENTATIVES FROM ANY AND ALL DAMAGES AND CAUSES OF ACTION EITHER AT LAW OR IN EQUITY THAT I MAY HAVE AS A RESULT OF MY [OR MY CHILD'S] PARTICIPATION IN, ATTENDANCE AT, AND TRAVEL TO AND FROM THE EVENT.

FURTHERMORE, I DO HEREBY EXPRESSLY STIPULATE, AND AGREE TO INDEMNIFY AND HOLD FOREVER HARMLESS THE LUTHERAN CHURCH—MISSOURI SYNOD, WESTIN ARLINGTON GATEWAY HOTEL – ARLINGTON, VA AND _____ (NAME OF HOME CONGREGATION), ITS AGENTS AND SERVANTS, SUCCESSORS AND ASSIGNS, DIRECTORS, TRUSTEES, OFFICERS, EMPLOYEES, AND OTHER REPRESENTATIVES AGAINST LOSS FROM ANY AND ALL PRESENT OR FUTURE CLAIMS, DEMANDS OR ACTIONS IN LAW OR IN EQUITY THAT MAY HEREAFTER BE MADE OR BROUGHT BY ME OR MY CHILD, BY ANYONE ON BEHALF OF ME OR MY CHILD, OR BY ANYONE ELSE ON THEIR OWN BEHALF FOR DAMAGES OR ANY OTHER LEGAL OR EQUITABLE REMEDY ON ACCOUNT OF ANY INJURY, ILLNESS, PHYSICAL CONDITION, INCONVENIENCE OR LOSS SUSTAINED BY ME OR MY CHILD DURING THE EVENT OR TRAVEL TO AND FROM THE SAME.

I, the undersigned, hereby acknowledge that I have read the foregoing, understand its contents, and have signed the same as my own free act and deed.

Name of participant: _____

Parent/Guardian of Participant
(if Participant is under 18)

Date

Witness

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Authorization to Consent to Medical and Dental Care

This form must be completed and signed by parent/guardian of participants under 18.

A parent/guardian signature is needed for participant to take part in LCMS Life Conference 2019 activities.

(I)(We), the undersigned parent(s) and/or natural guardians(s) of _____, a minor, do hereby authorize my child's congregational Adult Leader, (and/or any other adult appointed or designated by him/her) to (i) consent to medical, surgical and dental care for such minor child, (ii) consent to any diagnostic tests, medical, surgical or dental procedure or treatment as may be considered therapeutically necessary by the physician, surgeon, dentist or other health care personnel providing care for such minor child, and (iii) on (my)(our) behalf, to (a) employ physicians, surgeons, dentists, nurses, and other health care personnel as may be deemed necessary for such minor child, (b) admit such minor child to any hospital, clinic, emergency room, laboratory or other health care or diagnostic facility for examination, treatment, surgery or care, and (c) sign all necessary consents and authorizations. It is understood that this authorization is given in advance of the occurrence of any condition or situation which would necessitate any such medical, surgical, or dental care being required but is given to provide authority to obtain such care if it should be required. I fully understand the consequences of the foregoing statements and sign this AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE knowingly, freely and willingly.

This authorization shall continue for such time as my child is participating in the LCMS Life Conference 2019 and during travel to and from the LCMS Life Conference 2019.

(Parent/Legal Guardian)

(Date)

(Parent/Legal Guardian)

(Date)

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Emergency Medical Information Form

Please complete so that health providers can be aware of your personal health needs.
This form must be completed and carried by **ALL** LCMS Life Conference 2019 participants.

Name of Participant: _____

Does participant have: (if “yes”, explain)

- Yes No ALLERGIES? _____
Yes No HEART CONDITION? _____
Yes No OTHER? _____

Is participant subject to: (If “Yes”, explain)

- Yes No HEADACHES? _____
Yes No SEIZURES? _____
Yes No MOTION SICKNESS? _____
Yes No FAINTING? _____
Yes No SLEEP WALKING? _____
Yes No UPSET STOMACH? _____
Yes No OTHER? _____

Does participant have reaction to: (If “Yes”, explain)

- Yes No BEE STING? _____
Yes No PENICILLIN? _____
Yes No OTHER DRUGS? _____
Yes No POISON IVY, OAK, SUMAC? _____
Yes No OTHER? _____
Yes No Has the participant had any serious illness or surgery within the past ten years? Please list:

Yes No Does the participant have any condition that would prevent him/her from participating in any LCMS Life Conference 2019 activities? Please list:

Yes No Does the participant take any prescription medication? Please list:

Emergency Medical Information Form (continued)

- Yes No Are any drugs ineffective in treatment? _____
- Yes No Is the participant diabetic? Medication? _____
- Yes No Does the participant have any sight or hearing impairment? _____
- Yes No Does the participant wear contact lenses? _____
- Yes No Does the participant wear hearing aids? _____

Blood type: _____ Date of last Tetanus shot? _____

A current tetanus shot is required. After 7 years another tetanus shot is recommended.

Please indicate ANYTHING else that the leaders should know to help avoid or deal with any medical situation that might arise:

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Parental Information Sheet

Date: January 17-19, 2019
Location: Westin Arlington Gateway Hotel
801 North Glebe Road
Arlington, VA 22203

Phone: 703-717-6200

Congregational Contact Information

Adult leader: _____ Cell phone: _____
Adult leader: _____ Cell phone: _____
Adult leader: _____ Cell phone: _____
Adult leader: _____ Cell phone: _____
Adult leader: _____ Cell phone: _____

On-site Emergency Contact Number

Deaconess Dorothy Krans, LCMS Office of National Mission, Cell: 314-660-9406

Travel Information

Driving

Departure date: _____ Time: _____ Location of departure: _____
Arrival in Arlington date: _____ Est. time: _____
Return date: _____ Time: _____
Arrival home date: _____ Est. time: _____ Location of return: _____

Air Travel (if necessary)

Departure date: _____ Time: _____ Airline: _____ Flight #: _____
Arrive in Arlington date: _____ Time: _____ Airline: _____ Flight #: _____
Return date: _____ Time: _____ Airline: _____ Flight #: _____
Arrive home airport: _____ Time: _____ Airline: _____ Flight #: _____