C.L.A.S.S Student Leadership Experience

Oct. 18-20, 2018 - Concordia University-Nebraska

Please complete this form and return it along with the $40 non-refundable registration price by cash or check by October 2, 2018.

Checks should be made payable to "OKLAHOMA DISTRICT LCMS" with CLASS in the memo line.

Mail to: Oklahoma District Youth
c/o Suzanne Watt
Christ the Redeemer Lutheran Church
2550 E 71st St
Tulsa, OK 74136

YOUTH INFORMATION

Name _____ Grade _____ DOB _____ Male/Female

Nickname_____ School: _____

Primary Address:_____

Secondary Address: _____

Youth Email _____

Youth Home Phone _____ Youth Cell Phone _____

Congregation _____ Pastor_____

PARENT/ GUARDIAN INFORMATION

Name(s) _____

Email(s) _____

List all phone numbers where the parent/guardian can be reached (type: i.e. home, cell)

Name_____ #_____ Type? _____

Name_____ #_____ Type? _____

Name_____ #_____ Type? _____

Name_____ #_____ Type? _____

EMERGENCY CONTACT

Name_____ #_____ Relation? _____

Name_____ #_____ Relation? _____

PARENTAL CONSENT

The undersigned does hereby give permission for my child/youth _____ (child's name)("Participant"), to attend in C.L.A.S.S., sponsored by Concordia University-Nebraska and the Oklahoma District LCMS Youth Ministry, at Concordia University in Seward, Nebraska, on October 18-20, 2018.

LIABILITY RELEASE: In consideration of Concordia University- Nebraska and the Oklahoma District LCMS allowing

the Participant to participate, I, the undersigned, do hereby release, forever discharge and agree to hold harmless Concordia University- Nebraska and the Oklahoma District LCMS, its pastors, directors, employees, volunteers and teachers (collectively herein the "University and District") from any and all liability, claims or demands for accidental personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the Participant while involved in the activities. I, the parent or legal guardian of this Participant, hereby grant my permission for the Participant to participate fully in the activities, including trips away from the university premises. Furthermore, I, on behalf of my minor Participant, hereby assume all risk of accidental personal injury, sickness, death, damage and expense as a result of participation in recreation and work activities involved therein. The undersigned further hereby agrees to hold harmless and indemnify said University and District for any liability sustained by said University and District as the result of the negligent, willful or intentional acts of said Participant, including expenses incurred attendant thereto.

MEDICAL TREATMENT PERMISSION: I authorize an adult, in whose care the minor has been entrusted, to consent to any emergency x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital or emergency care facility. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned youth pursuant to this authorization. I declare that my child is covered by primary accident and medical insurance.

EARLY RETURN HOME POLICY: Should it be necessary for my youth to return home due to medical reasons, disciplinary action or otherwise, the undersigned shall assume all transportation costs and responsibility.

If paying for and requesting District transportation, please initial that you have read and understood the following statement otherwise please leave it blank.

☐ TRANSPORTATION PERMISSION: The undersigned does also hereby give permission for my youth to ride in any vehicle driven by an approved and licensed adult chaperone or hired driver while attending and participating in activities sponsored by the University and District. I, the undersigned, do hereby release, forever discharge and agree to hold harmless the Oklahoma District LCMS, its pastors, directors, employees, volunteers and teachers from any and all liability, claims or demands for accidental personal injury or death. My youth and I understand that SEAT BELTS MUST BE WORN AT ALL TIMES during transportation.

_____	x_____	_____
Print name of youth participant	Signature of youth participant	Date
_____	x_____	_____
Print name of parent/guardian	Signature of parent/guardian	Date

EVERYONE MUST COMPLETE: Photo Release Form on page 3 and return it with registration form.

<u>If you are sending your youth without a congregational chaperone</u>, please complete the following Medical Information Form on pages 4, 5, 6, 7 and return it with your registration. Congregational chaperones will be expected to carry medical forms for their participants.

<u>If your youth has a Food Allergy or Special Dietary Need</u>, please complete the Form on page 8 and return it with your registration so Concordia is aware.

Oklahoma District Photo Release Form

for Children and Youth

Please initial one option:

- ☐ I/We AGREE that Concordia University- Nebraska and the Oklahoma District LCMS may photograph and record my child/dependent's likeness and activities (Images)[1] during district-related activities. I grant the following rights to Concordia University-Nebraska and the Oklahoma District LCMS: permission to use and re-use, publish and re-publish, and modify or alter the Image(s) taken during the shoot. Use of the Images for editorial, commercial, trade, advertising, and any other purpose may be done in any medium now existing or subsequently developed, on the church website and on the Internet, and worldwide in perpetuity for the purposes stated above.

  I waive my right to inspect or approve any editorial text or copy that is used in connection with the Images and release and discharge Concordia University-Nebraska and the Oklahoma District LCMS from any and all claims arising out of use of the Images for the purposes described above, including any claims for libel, invasion of privacy, or other tortuous act.

  I have read the foregoing. I fully understand its contents, understand that this agreement does not expire, and confirm my agreement by signing below. I am over the age of 21 and have legal capacity to sign the release.

- ☐ I/We DO NOT GRANT permission for any image that includes this youth to be published by Concordia University-Nebraska or the Oklahoma District LCMS. Concordia University-Nebraska or the Oklahoma District LCMS MAY NOT use and re-use, publish and re-publish, and modify or alter the Image(s). Use of the Images for editorial, commercial, trade, advertising, and any other purpose MAY NOT be done in any medium now existing or subsequently developed, on the church website and on the Internet, and worldwide in perpetuity for the purposes stated above.

Youth's Name (print) _____ Parent/Guardian Name (print) _____

x

Parent/Guardian Signature _____ Date _____

[1] Image means all photographs, film, or other recordings taken of you as part of the Shoot.

MEDICAL INFORMATION

YOUTH INFORMATION (*Please Print)*

Youth Full Name _____ Nickname _____

Home Address _____

Home Phone _____ DOB _____

PRIMARY CARE PHYSICIAN

Name:_____

Phone(s)_____ Fax: _____

Name of practice: _____

Date of last Tetanus shot _____

DENTIST

Name:_____

Phone(s)_____ Fax: _____

Name of practice: _____

INSURANCE INFORMATION

Medical Insurance Company: _____ Phone: _____

Policy/Group ID#: _____ Policy

Holder's Name (please print): _____

Required: Attach a front and back copy of medical insurance card here.

MEDICATION:

List all medications the youth will bring with him/her during any youth ministry trips, retreats, or events. This includes any prescription, non-prescription medications, herbal supplements and vitamins. Any participant under the age of 18 is required to give **ALL MEDICATIONS to the adult youth leader in their original containers with complete dispensing instructions before the start of the event. Youth are not permitted to carry any prescription or non-prescription medication and will be sent home at the parent/guardian's expense if they do.**

Medication Name	Dose	Treatment for	Dispensing instructions
Example: Zyrtec	*5mg*	*Seasonal allergies*	*Take one pill daily in the morning with food*

_____

_____

_____

_____Over-the-Counter Medication Permission: Do you give permission for your child/youth to be given over-the-counter medication as needed and as directed on the label, to treat non-emergency medical conditions that do not require a doctor or hospital visit such as a minor headache, stomachache, or allergic reaction (i.e. Tylenol, Advil, antacids, Benadryl) while at a youth ministry event?

☐ **No**. Contact me or get medical help if my child has any minor medical concerns.
Parent signature_____

☐ **Yes.** I give permission for an adult youth leader to give my child approved over-the-counter medications as directed on the **Over the Counter Medication Permission form** on an as needed basis to treat non-emergency medical conditions.
Parent Signature_____

MEDICAL CONDITIONS: Please answer in detail if applicable or write N/A. Attach additional pages if necessary.

1. List any medical conditions you have (asthma, diabetes, epilepsy, etc.):

2. List any allergies (drug/medicine, food, and/or environmental):

IF ANY ARE LISTED, PLEASE COMPLETE THE ADDITION ALLERGY ACTION PLAN FORM.

- Does your child carry and epi pen? Does your child carry an inhaler?

3. Please explain any other pertinent information about the participant (i.e. physical, behavioral, or emotional) that would be important for the adult leaders to know.

OVER THE COUNTER MEDICATION PERMISSION FORM

Youth Name: _____ Age: _____ DOB: _____

Sometimes at youth events youth have non-emergency medical issues such as headaches, stomachaches, or allergic reactions. This form allows the youth director or other supervising adult (over the age of 21) to give medication in these instances. **Please initial by each medication whether your child is permitted to be given that medication according to the directions on the bottle should he/she request it.**

Should your child have a minor illness such as a headache, stomachache or allergic reaction, can these medications be given to your child?

Medication	Yes	No
Anti-itch cream (i.e. Benadryl)		
Acetaminophen (i.e. Tylenol)		
Ibuprofen (i.e. Advil)		
Antihistamine (i.e. Benadryl)		
Antacid (i.e. Tums)		
Anti-diarrheal (i.e. Imodium)		
Other:		

This permission is for my child, _____ (youth name). I understand that that no medication can be given unless initialed on this form. I understand that this medication will only be given if a youth asks for it and according to the directions on the bottle. I understand that all medications are to be given by a supervising adult who is over the age of 21.

I understand that if my child brings any medication to a youth event, over the counter or prescription, even if it is listed on this form, there is a separate Medication Form that must be filled out. I also understand that any medication brought to a youth event must be turned in to the youth director or another supervising adult, unless agreed upon with the leader of an event in the case of medications that need to be immediately accessible, such as Epi-Pens and inhalers.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

Youth Name _____

DOB _____

Allergy to _____

Asthmatic? ☐ Yes ☐ No

STEP 1 - TREATMENT

SEND STUDENT TO PRIMARY ADULT LEADER ACCOMPANIED BY A RESPONSIBLE PERSON.

The severity of symptoms can quickly change. †Potentially life threatening.

Give checked Medication**

***Unless otherwise determined by physician authorizing treatment*

Symptoms

☐ If a student has been exposed to/ingested an allergen but has NO symptoms:	☐ Epinephrine ☐ Antihistamine
☐ Mouth Itching, tingling, or swelling of lips, tongue, mouth:	☐ Epinephrine ☐ Antihistamine
☐ Skin Hives, itchy rash, swelling of the face or extremities:	☐ Epinephrine ☐ Antihistamine
☐ Gut Nausea, abdominal cramps, vomiting, diarrhea:	☐ Epinephrine ☐ Antihistamine
☐ Throat† Tightening of throat, hoarseness, hacking cough:	☐ Epinephrine ☐ Antihistamine
☐ Lung† Shortness of breath, repetitive coughing, wheezing:	☐ Epinephrine ☐ Antihistamine
☐ Heart† Thready pulse, low blood pressure, fainting, pale, blueness:	☐ Epinephrine ☐ Antihistamine
☐ Other† _____ :	☐ Epinephrine ☐ Antihistamine

MEDICATION:

Epinephrine: Inject intramuscularly.

☐ Epinephrine Autoinjector 0.3mg

☐ Epinephrine Autoinjector 0.15mg

Important: Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis.

Antihistamine: Give _____

antihistamine/dose/route

Other: Give _____

medication/dose/route

Parent/Guardian Signature _____ **Date** _____

Prescriber Name_____ **Phone**_____

STEP 2 - EMERGENCY CALLS

PARAMEDICS (911) MAY BE CALLED IF EPIPEN OR AUVI-Q IS GIVEN.

We will send empty autoinjector to ER with student. Parent/Guardian will be contacted. EVEN IF PARENT/GUARDIAN IS UNAVAILABLE, WE WILL MEDICATE CHILD & CALL 911.

FOOD ALLERGY & SPECIAL DIETARY NEED

Name of Event: _____ Dates: _____

Youth Name: _____ Age: _____

Church: _____

Parents Name: _____ Phone #:

_____

Is parent attending event with youth? _____

If not, please list name of chaperone who will be assigned to provide assistance _____

Is youth aware of his/her allergies or dietary needs? _____

Is youth able to monitor his/her own food requirements without assistance from an adult chaperone? _____

*It is expected that high school students can monitor their requirements without constant assistance from a chaperone although we do understand that in extreme cases they may require additional help.

List allergies or explain special dietary needs, please be as specific as possible:

_____

_____

_____

_____

Is child bringing some of his/her own food? _____ If so please list below:

_____

_____

_____

All food must be labeled with youth's name directly on packaging.