Native Works of Lakota Training and Leadership Institute

Adult Medical Release Form

I, the undersigned,_____ hereby willingly consent to attend a mission trip operated by Lakota Training and Leadership Institute . In the event that I am injured while attending the trip and require the attention of a doctor, I consent to any reasonable medical treatment as deemed necessary by a licensed physician. I the event treatment is called for, which a physician and/or hospital personnel refuses to administer without my consent, and an occasion arises whereby I am unable to give such consent, I hereby authorize _____ or a member of the Lakota Training and Leadership Institute staff to give such consent for me.

In the event it becomes necessary for that person to give consent for me, I agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent to long as the treatment is administered by or under the supervision of a licensed physician. I also acknowledge that I will be ultimately responsible for the cost of any medical care, should the cost of that medical care not be reimbursed by the heath insurance carrier.

Further, I affirm that the health insurance information provided below is accurate at this date and will to the best of my knowledge, still be in force at the time of my stay at the Lakota Training and Leadership Institute.

Name of Health Insurance Policy Holder_____

Health Insurance Policy Holder's Telephone Number_____

Health Insurance Policy Number #_____

Insurance Carrier's Name, Address and Telephone Number_____

_____

Name, Address, and Telephone Number of Policy-Holder's Employer_____

_____

Your Name and Signature:

_____

Print Name Signature Date of Birth

Social Security Number_____ Today's Date_____

Known allergies and current medications_____

_____

Date of last Tetanus shot_____

- *Please attach a copy of your insurance card to this form.*