



Native Works of Lakota Training and Leadership Institute

Child/Student Medical Release Form

I/We, the undersigned, are the parent(s), the parent(s) having legal custody, or the legal guardians of _____ (print child's full name), a minor, and have given our consent for him/her to attend a mission trip operated by Lakota Training and Leadership Institute. In the event that he/she is injured while attending the trip and require the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is called for, which a physician and/or hospital personnel refuses to administer without my/our consent, I/we hereby authorize _____ (name of authorized person), the lead adult of our group, or a member of the Lakota Training and Leadership Institute staff to give such consent for me/us if I/we cannot be reached by telephone at one of the numbers listed below, or because of an emergency, there is not time or opportunity to make a telephone call.

In the event it becomes necessary for that person to give consent for me/us, I/we 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/we also acknowledge that I/we will be ultimately responsible for the cost of any medical care, should the cost of that medical care not be reimbursed by the health insurance carrier.

Further, I/we affirm that the health insurance information provided below is accurate at this date and will to the best of my/our knowledge, still be in force at the time for the student/child above at the time of their 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 _____

Child's/Student's Name and Signature:

Print name _____ Signature _____ date of birth _____

Social Security Number _____ Today's date _____

Parent(s)/Guardian(s) Name and Signature (if participant is under 18):

Print name _____ Signature _____ Relationship to Child/ Student _____

Print name _____ Signature _____ Relationship to Child/ Student _____

Today's Date _____

Known allergies and current medications _____

Date of last Tetanus shot _____

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