5th Grade
FEED MY STARVING CHILDREN & OVERNIGHT
Day Camp Experience!
Tuesday, June 12 – Wednesday, June 13

At 10:30 a.m. on Tuesday, we will go to FEED MY STARVING CHILDREN in Coon Rapids and after to SPRING BROOK Nature Reserve to eat lunch and hike. For supper, we will go to PIZZA RANCH, and then head back to church to do a few more activities.

Please Bring: your sleeping bag, favorite stuffed animal, pillow, pajamas, a change of clothes, toothbrush, toothpaste, bug spray, sunscreen, a rain poncho/jacket, and **TWO LUNCHES** (one for Tuesday and one for Wednesday). You need to **WEAR closed-toed shoes** to work at FMSC as you cannot pack food without them.

____ has my permission to participate in **Trinity's 5th Grade Day Camp Experience (Feed My Starving Children, hiking & overnight) on Tuesday & Wednesday, June 12-13, 2018.** I recognize that there are risks involved in participating in this activity with Trinity Lutheran Church and hereby assume all risk of injury, harm, or damage to my minor child as they participate in this activity. I hereby release and agree to hold harmless Trinity Lutheran Church and its employees, organizers, and any volunteers assisting in the program, from any and all liability and claims arising out of my child's participation in programs and related activities. I hereby release Trinity Lutheran Church, its staff and sponsors, from responsibility and liability for any injury or illness that my child may sustain during the event.

In case of emergency, where I cannot be reached, I hereby authorize Trinity to administer necessary first aid or seek emergency medical attention for my child. I hereby authorize an adult leader of this event, as agent for me, to consent to any x-ray examination; medical, dental or surgical diagnosis; treatment; and/or hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at the doctor's office or in any hospital. I expect to be contacted as soon as possible. I understand that I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital care or treatment that is given to my minor child.

I give my permission for my child to be photographed/videotaped. I understand that the images may be displayed in church publications, church building, website and/or social media. I understand that as a precaution, my child's names will NOT be published or linked with photographs.

____ ____________________

Signature of Parent/Guardian Date

Phone(s)____

EMERGENCY INFORMATION: In case of emergency, please contact (when parent/guardian cannot be reached):

Name____ **Relationship**________________

Phone(s) ____

MEDICAL INFORMATION: ***(Please provide a copy of your medical insurance card.)***

DOCTOR ____ Phone_____________________

CIRCLE ONE: **C. L. Clinic 651-257-8400 ✦ Fairview-Wyoming 651-982-7000 ✦ St. Croix Clinic 1-800-642-1336**

Please list any allergies____

Medications being taken____

Medical/dietary needs____

Physical handicaps or limitations ____

Medical insurance company ____________________ Policy#________________ Group # __________