NEW HOPE CENTRAL OAHU

P.O. Box 893855, Mililani, HI 96789

PARENT/GUARDIAN AUTHORIZATION AND CONSENT FORM

Activity Information:

Activity :Chi Camp 2016 Location: Camp Erdman ,Hi

Date: Friday, April 8 – Sunday, April 10 Time: Drop off 4:30pm - Pick up 11:30am

Group: CHI Cost: $150.00 Transportation : All Youth must be dropped off by an adult

Emergency Contact: Phone contact(s) Steven 398-5229, Lei 369-4110

I hereby grant permission for my child to participate in the activity named above. I agree to release and hold harmless New Hope Central Oahu, including its staff, officers, volunteer leaders, and/or designees from all liability in the event of bodily injury, personal property damage, loss and/or death that may result from travel and involvement in this activity.

This authorization and consent form will remain effective during the dates, inclusive, specified above.

Kim Abela Nakashima Activity Leader

Kanani Viloria Activity Leader

Pastor Mark Palompo

MEDICAL/EMERGENCY CONTACT INFORMATION – MUST BE COMPLETED

This release gives us permission to take your child to the nearest available medical facility and have the necessary treatment administered. This is necessary, as most hospitals will not administer any medical attention to a minor without parental consent. Therefore, please read the following statement and sign below. This will allow us permission to seek whatever medical attention we deem necessary for your child or children.

In case of an emergency, I understand that every effort will be made to contact me. If I cannot be reached, I hereby give Steven Ho, Lei Olayon (adult or youth leader in charge of group) permission to act on my behalf in seeking emergency treatment for my child in the event that such treatment is deemed necessary. I give permission to those administering emergency treatment (physician, surgeon, dentist, medical practitioner, or medical facility licensed to practice medicine by the appropriate authorizing agency) to do so, using those measures deemed necessary. I further agree to be responsible for such medical or dental costs incurred. I understand this authorization is given in advance of any specific diagnosis or treatment.

Name of Youth (Please print) Age Birth date

Signature of parent or guardian Phone contact

Name of family doctor Phone contact

Preferred Hospital