

Parent(s)/Guardian(s) Delegation of Powers by Power of Attorney

Pursuant to Section 15-14-105 C.R.S., the undersigned parent(s)/guardian(s) of the following minor child: \_\_\_\_\_, hereby delegates to the adult leaders of St. Andrew United Methodist Church youth program, designated as agents for this purpose, the undersigned's power of care and custody of the above named minor person, including but not limited to, the power to authorize all medical, dental and hospital care for the above named person and the power to execute all documents and releases necessary to obtain such care. I/We agree that St. Andrew shall have no financial liability for any such treatment, and I/We agree to be fully and exclusively liable for all expenses and to reimburse St. Andrew if it advances any expenses. I/We grant the designated agents the forgoing power with the respect to the above named person for a period ending twelve months from day this Power of Attorney is signed. I/We give permission for my/our child to participate in the activity for which he/she is registered in consideration of my/our child's participation in the activity for which he/she is registered. I/we, for myself/ourselves and for my/our heirs, legal representatives and assigns, covenant with St. Andrew United Methodist Church to never institute any suit or action at law or in equity against St. Andrew United Methodist Church, its representatives, assigns, officers, staff or volunteers, for any sickness, injuries or death of my/our child resulting from participation in the activity for which my/our child is registered. I/We give permission for my/our child's image to be used in church-related print and web media. In executing this covenant, I/we expressly reserve any and all rights, causes of action, claims and demands against any person, firm or corporation other than St. Andrew United Methodist Church, its representatives, officers, staff or volunteers. Photocopies of this document shall be effective and enforceable as the original, and third parties shall be entitled to rely on photocopies of this document for the full force and effect of all stated terms.

Medical Insurance Company: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy No. \_\_\_\_\_

Group No. \_\_\_\_\_

DATED this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Signature of parent/guardian \_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Business phone \_\_\_\_\_

STATE OF COLORADO, COUNTY OF \_\_\_\_\_

The foregoing Delegation of Powers by Power of Attorney and Covenant Not to Sue was subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_,

by \_\_\_\_\_ (parent/guardian).

Witness my hand and official seal. My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Notary Public

MEDICAL INFORMATION

1. Is there a history of chronic infection of nose, throat, ears, sinus or lungs? \_\_\_\_\_  
If so, describe: \_\_\_\_\_
2. Is there a history of heart pathology requiring restricted activity? \_\_\_\_\_
3. Is this person subject to any skin disease? \_\_\_\_\_
4. List ALL allergies (medications, food, plants, animals, bee stings, other, please specify):  
\_\_\_\_\_
5. Has there been recent illness or exposure to contagious disease? \_\_\_\_\_  
If so, describe: \_\_\_\_\_
  
6. Is this person subject to fainting, convulsive seizures, nose bleeds, cramps or asthma? \_\_\_\_\_  
Is he/she diabetic? \_\_\_\_\_ What medication is prescribed for the preceding conditions? \_\_\_\_\_
7. Limitations of activity: \_\_\_\_\_
8. Is there any drug or medication to be taken regularly? \_\_\_\_\_
9. Other recommendations: \_\_\_\_\_
10. Date of last tetanus shot: \_\_\_\_\_
11. Participant's doctor, address and phone # \_\_\_\_\_
12. Participant's Date of Birth \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_