

## PERMISSION SLIP and MEDICAL RELEASE FORM

**Event:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Participant's Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Current Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby grant permission for my child to participate in the above activity of the Saint Matthew Lutheran Church Youth Group. I understand that my child participates in these activities at their own risk and that the Saint Matthew Lutheran Church and its adult supervisors are not liable for any injury personal or otherwise to my child or caused by my child. Should any problems arise concerning the behavior of my child that would require them to return home prior to the end of the activity, I will pay for his or her return or come pick my child up.

I recognize that the Saint Matthew Lutheran Church uses photographs and video images of events in our publicity materials such as the church website, newspapers, and newsletters and I hereby grant permission for photo/video images of my child to be taken and used for such purposes.

I authorize the treatment, by a qualified and licensed medical doctor, of the minor listed above in the event of any medical emergency which, in the opinion of the attending physician, is necessary and I/we cannot be reached after reasonable effort has been made to secure my personal consent.

I am responsible for any medical expenses.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent or legal guardian)

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Other Pertinent Contact Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Youth Group 2007-8**

Permission Slip and Medical Release Form

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Participant Name: \_\_\_\_\_

Emergency Contacts:

1. Name: \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Day Phone (\_\_\_\_) \_\_\_\_\_ Night Phone (\_\_\_\_) \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Day Phone (\_\_\_\_) \_\_\_\_\_ Night Phone (\_\_\_\_) \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Policy #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

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

Telephone Number (\_\_\_\_) \_\_\_\_\_

Special Medical Conditions--Allergies, chronic illness, or other conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications:

\_\_\_\_\_

\_\_\_\_\_

Any other information (special needs, concerns):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_