

# YOUTH PERMISSION SLIP & EMERGENCY MEDICAL INFORMATION FORM

I hereby give my son/daughter, \_\_\_\_\_, permission to attend the Youth trip to \_\_\_\_\_. I/We, the undersigned parent(s) and/or natural guardian(s) of \_\_\_\_\_, a minor, do hereby authorize my child's adult leader (and/or any other adult appointed or designated by him/her)

- (i.) to consent to medical surgical and dental care for such minor child
- (ii.) to consent to any diagnostic tests, medical, surgical or dental procedure or treatment as may be considered therapeutically necessary by the physician, surgeon, dentist, or other health care personnel providing care for such minor child, and
- (iii.) on my/our behalf, to
  - (a) employ physicians, surgeons, dentists, nurses, and other health care personnel as may be deemed necessary for such minor child,
  - (b.) admit such minor child to any hospital, clinic, emergency room, laboratory or other health care or diagnostic facility for examination, treatment, surgery, or care and
  - (c) sign all necessary consents and authorizations.

It is understood that this authorization is given in advance of the occurrence of any condition or situation which would necessitate any such medical, surgical, or dental care being required but is given to provide authority to obtain such care if it should be required. I fully understand the consequences of the foregoing statements and sign this *YOUTH PERMISSION SLIP & EMERGENCY MEDICAL INFORMATION FORM* knowingly, freely, and willingly.

I understand that I have a duty to provide primary accident and medical insurance for myself (or for my child) and I declare that I am (or my child is) covered by primary accident and medical insurance.

*I release and forever discharge Immanuel Baptist Church, their agents and servants, successors and assigns, directors, trustees, officers, employees, and other representatives from any and all damages and causes of action either at law or in equity that I may have as a result of my (or my child's) participation in, attendance at, and travel to and from the event. Furthermore, I do hereby expressly stipulate and agree to indemnify and hold forever harmless at Immanuel Baptist Church, its agents and servants, successors, and assigns, directors, officers, employees, and other representatives against loss from any and all present or future claims, demands, or actions in law or in equity that may hereafter be made or brought by me or my child, by anyone on behalf of me or my child, or by anyone else on their own behalf for damages or any other legal or equitable remedy on account of any injury, illness, physical condition, inconvenience, or loss sustained by me or my child during this event or travel to and from the same.*

I, the undersigned, hereby acknowledge that I have read the foregoing, understand its contents, and have signed the same as my own free act and deed.

\_\_\_\_\_  
PARENT/GUARDIAN OF PARTICIPANT

\_\_\_\_\_  
DATE

# CONSENT AND LIABILITY WAIVER FORM

Each participant of the \_\_\_\_\_ must complete all spaces on this Consent and Liability Waiver Form as well as the Permission slip on the reverse side. These forms must be returned to Dustin or Victoria in order for the participant to attend this event. Please type or print in ink.

**PARTICIPANTS NAME** \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

**PARENT/GUARDIAN** \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ EMAIL \_\_\_\_\_

\_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

NAME & RELATIONSHIP OF ANOTHER PERSON TO CONTACT (IF A RELATIVE, IDENTIFY RELATIONSHIP)

\_\_\_\_\_ PHONE ( ) \_\_\_\_\_

**HEALTH PLAN CARRIER** \_\_\_\_\_

POLICY # \_\_\_\_\_ INSURANCE AGENT PHONE ( ) \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_

**FAMILY DOCTOR** \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

MEDICAL EXCHANGE ( ) \_\_\_\_\_

**FAMILY DENTIST** \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

1. Do any pre-certification, notification, or other requirements exist with respect to the health insurance of participant? If so, please specify: \_\_\_\_\_
2. Please note any allergies which the participant has: \_\_\_\_\_
3. Is the participant taking any medication? If so, please describe/list: \_\_\_\_\_  
\_\_\_\_\_
4. Are there any allergies or other medical conditions of which leaders/medical personnel should be aware? If so, please describe: \_\_\_\_\_