TRINITY ALLIANCE YOUTH

Contact Info Form | Please complete one form per student.

STUDENT INFO

Name: _____

Grade: _____

Birthday (month/day/year): _____/_____/_____

Cell* (optional): _____

**This is used solely for communication within a group setting of students and/or leaders to share event info/reminders, prayer requests and scripture/devotional encouragements. No student will be contacted privately by a leader without specific permission from a parent/guardian.*

STUDENT MEDICAL / ALLERGY INFO

☐ None Known

PARENT / GUARDIAN INFO

Name #1: _____

Cell: _____

Email: _____

Name #2: _____

Cell: _____

Email: _____

SafeChurch

GuideOne Insurance

Minor Participation Authorization and Consent to Emergency Medical Treatment Form

I, the undersigned, certify that I am the parent or legal guardian of the child (hereafter referred to as "minor child") listed on this sheet.

I hereby give my consent to have my minor child participate in the activities of Trinity Alliance Church **Youth Group** (hereafter "the activity").

I recognize that there may be risks involved in participating in this activity and hereby assume all risk of injury, harm, damage, or death to my minor child in connection with his/her participation in this activity.

To the fullest extent permitted by law, I release Trinity Alliance Church, its trustees, officers, directors, employees, agents and representatives from any injury, harm, damage or death which may occur to my minor child while participating in the activity and agree to save and hold harmless Trinity Alliance Church, its trustees, officers, directors, employees, agents and representatives from any claims arising out of my minor child's participation in the activity.

Further, being the parent or legal guardian of the minor child, I do consent to any medical, surgical, x-ray, anesthetic, or dental treatment that may be deemed necessary for my minor child. I understand that efforts will be made to contact me prior to treatment but, in the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. As parent or legal guardian, 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. Any insurance policy of the church or organization sponsoring this event will be used as the secondary coverage.

Executed this _____ day of _____, 20___.

Name of Minor _____

Signature of Parent / Legal Guardian _____

Printed Name _____