YOUTH RETREAT PERMISSION SLIP

Date: _____ | Location: _____

STUDENT INFO

Youth Name: _____

Age: _____ Grade: _____

Phone Contact: _____

****MEDICAL / FOOD ALLERGIES / MEDICATIONS:**
(use the back of this sheet for additional space)

EMERGENCY CONTACT INFO

Parent/Guardian Name: _____

Phone Contact: _____ ☐ cell ☐ home

Phone Contact: _____ ☐ cell ☐ home

INSURANCE INFORMATION

Insurance Provider: _____

Policy/Group #: _____

PARENTS/GUARDIANS: Please sign the attached medical consent form. If you have any questions regarding this form or other details about the trip, please contact Jeff (609-703-1474).

Minor Participation Authorization and Consent to Emergency Medical Treatment Form

I, the undersigned, certify that I am the parent or legal guardian of the following minor student (hereafter referred to as "student"): _____

I hereby give my consent to have my student participate in the following activity of Trinity Alliance Church: _____ (hereafter "the activity") on _____.

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 student 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 student 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 student's participation in the activity.

Further, being the parent or legal guardian of the student, I do consent to any medical, surgical, x-ray, anesthetic, or dental treatment that may be deemed necessary for my student. 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 student. As parent or legal guardian, I understand that I am responsible for the health care decisions of my student 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 student. Any insurance policy of the church or organization sponsoring this event will be used as the secondary coverage.

Executed this _____ day of _____, 202__.

Parent/Guardian Signature_____

Printed Name_____