

FIRST LUTHERAN CHURCH
Children and Family Ministry
Event Permission Slip

One permission slip per family, please. This permission slip must be returned to the Director of Children and Family Ministry or to the church office prior to the date of the event for which it is to be used.

Name of Event: _____ Date: _____

Students' Name(s): _____ Birth Date: _____

_____ Birth Date: _____

_____ Birth Date: _____

_____ Birth Date: _____

Parent's Name(s): _____

Home Address: _____

Home Phone: _____ Cell: _____

Email address: _____

Emergency Contact Information- In the event of an emergency, please provide the requested information for someone that we can contact in the event you cannot be reached.

Name: _____

Relationship to student: _____

Address: _____

Home Phone: _____ Cell: _____

(over please)

Child's Special Needs – Please list below any special needs (ie. behavioral/learning needs, food allergies, etc.) that our staff should be aware of while your child(ren) is in our care.

Health Insurance Information and Release

While every effort is made to ensure the safety of each and every child, accidents do happen. Please supply your child's health insurance information in the event of any emergency.

Policy Holder's Name: _____

Insurance Company Name: _____

Insurance Company Address: _____

Policy/Member Number: _____

Primary Physician's Name: _____

Physician's Phone Number: _____

By my signature below, I consent to any ex-ray, examination, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care under the general supervision and upon the advice of or to be rendered by a physician, surgeon, and dentist licensed under the Medical Practice Act and Dental Practice Act. As parent or legal guardian, I am responsible for the health care decisions of my child and am authorized to consent to services to be rendered, and no other consent is required by law. I hereby give permission to the physician selected by the activities supervisory personnel then present to render medical treatment deemed necessary and appropriate by the physician or dentist. I will assume FULL FINANCIAL RESPONSIBILITY for care given.

I warrant and represent that I am eighteen years of age or over, and am fully aware of and understand the terms and legal consequences of the signing of this form. I intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

Parent/Guardian Signature: _____

Date: _____