Bethel Lutheran Church
Student Ministries

PERMISSION SLIP and MEDICAL RELEASE FORM

Participant's Name____

Street Address____

City ________________________ Zip____________

Current Grade_____ Date of Birth ________________

I hereby grant permission for my child to participate in the Bethel Lutheran Church Student Ministries. 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, the undersigned parent, individually and as guardian of the person of my student named herein, hereby release and discharge Bethel Lutheran Church, its employees, representatives, agents, servants, activity sponsors, chaperones, drivers (over the age of 18 years old), and any and all assigns thereof from all claims, actions, damages, expenses, and compensation whatsoever which may result from the participation of my child in activities sponsored by the Bethel Lutheran Church.

I recognize that Bethel 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.

My child may be given acetaminophen, ibuprofen, or Sudafed by the advisors as needed.

I authorize the treatment, by a qualified and licensed medical doctor, of the minor listed above in the vent of any medial 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.

Any medical expenses are the responsibility of the participant and their insurance carrier.

Signed: ____ Date:_____________

Home Phone: (_____)______________ Work Phone: (_____) __________________

Cell Phone: (_____)___________________________

Participants 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 #____________________________________

Primay Care Physician: ____

Address: ____

City __________________________ Zip__________ State________________

Telephone Number (____)_______________________

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

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Current Medications: ____

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Date of Last Tetanus shot:______________________________

Any other information: ____

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