

PARENT REQUEST TO PARTICIPATE & MEDICAL RELEASE FORM

Dear Parent or Legal Guardian:

Your son/daughter is eligible to participate in a church/school-sponsored event. This activity will take place under the guidance of _____. A brief description of the activity follows:

Name of Event: _____

Destination: _____

Designated Supervisor of Activity: _____

Date and Time of Departure: _____

Method of Transportation: _____

Approximate Cost: _____

If you would like your child to participate in this event, please complete, sign, and return the following statements of consent and release of liability. As parent or legal guardian, you remain fully responsible for any legal responsibility that may result from any personal actions taken by the named student.

I hereby consent to participation by my child, _____
In the event described above. I understand that this event will take place away from the church/school grounds and that my child will be under the supervision of the designate chaperons on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

Print Parent's Name	Cell Phone	Email
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Parent's Signature	Date
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SWORN TO and subscribed before me on this _____ day of _____ 20_____

NOTARY PUBLIC
(Seal)

My commission expires: _____

Only overnight trips require notarization.

YOUTH

Youth Trips & Other Functions MEDICAL RELEASE AND INFORMATION FORM (Medical Information for Overnight Trips/Retreats Only)

Name of participant _____ DOB _____

Medication presently on (Name and dosage for each)

Allergies (Foods, Medication, etc.):

Any other Medical conditions (asthma, diabetes, seizures etc)

Date of last tetanus shot _____

Parent contact: _____ Work Phone _____ Cell Phone _____ Email: _____

Contact Person (alternate) _____ Home Phone _____ Work Phone _____ Cell Phone _____

I hereby give my permission for my child to be administered medical help in case of an emergency. If you have medical insurance please indicate the following:

Insurance Company: _____ Phone: _____

Policy Name: _____ Policy Number: _____

Family Doctor: _____ Doctor's Phone Number: _____

Parents(s) Guardian(s) signature _____ Date: ___ / ___ / _____

Sworn To and subscribed before me on this _____ day of _____ 20_____

My commission expires: _____

Notary Public (seal)