

PERMISSION FORM FOR CHILDREN OR YOUTH PROGRAMS & ACTIVITIES

Participant's Name: _____

Preferred Name: _____

Date of Birth: _____

Male

Age: _____

Grade: _____

Female

Prefer not to share

Church Name: _____

City: _____

Participant's Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Email: _____

Emergency Contact

Parent(s) / Guardian(s)

Phone

If unavailable, please call

Phone

Medical

Allergies (including allergies to medication)

Are there any over-the-counter medications (Tylenol, Advil, etc.) which participant should not receive if any minor symptoms develop?

Medications sent with the participant

Note: Prescribed medications must be in original pharmacy container with the correct name, date, instructions, and physician's name on the label. The event nurse, if applicable, will keep and distribute all medications during the event.

Please notify the event coordinator or nurse if this participant has been exposed to any communicable disease within the three weeks prior to this event. Participants will NOT be allowed to attend if they arrive at the event ill.

Insurance Information

Insurance Company: _____

Phone: _____

Policy #: _____

Group #: _____