

HOPE UNITED METHODIST CHURCH EVENT PERMISSION/MEDICAL SLIP

(to be kept on file in the church office & children/youth program staff)

To Whom It May Concern:

Name of child/youth _____ has my permission to go with the

Name of group _____ to the following event _____

At the following location _____ Date of event _____

Signature of parent/guardian _____ Date _____

Phone number in case of emergency: _____

Alternate contact name and phone number: _____

Medical/Health Information:

Please list any medications, allergies (foods, insect bites, etc.), medical conditions (asthma, hay fever, etc.):

Other pertinent health history/information:

Does your child/youth have any conditions that would prevent him/her from fully participating in this program? If yes, please explain (specific foods/activities to avoid):

List any medication to be taken during the event which will be kept by the leaders during the event:

Preferred Doctor _____ Phone Number _____

Preferred Dentist _____ Phone Number _____

Preferred Eye Doctor _____ Phone Number _____

Preferred Hospital _____ Phone Number _____

EMERGENCY MEDICAL AUTHORIZATION

I give my consent for emergency medical treatment by certified first aid personnel. In the event that additional treatment is needed, the staff of the Emergency Room of the hospital listed above or one closest to the event location, has my permission to treat my child/youth.

Parent/Guardian Signature _____ Date _____

Parent Guardian Name (Print) _____

Address _____

Home Phone Number _____ Cell Number _____

Hospitalization Plan Name _____ Policy/Group Number _____

I understand that Hope United Methodist Church, its pastor(s), adult staff leaders, or counselors will not be held responsible for any injuries incurred during events held at the church or through church sponsored events that may take place off church property.

Parent/Guardian Signature: _____