

PERMISSION AND MEDICAL AUTHORIZATION FORM

I, THE UNDERSIGNED, GRANT PERMISSION FOR MY CHILD,
_____, TO ATTEND
_____.

I authorize Christus Lutheran Church to administer general first aid treatment for any minor injuries or illnesses experienced by my son or daughter in any of the aforementioned events. If the injury or illness is life threatening or in need of emergency treatment, I authorize Christus Lutheran Church to summon any and all professional emergency personnel to attend, transport, and treat the participant as deemed necessary by a licensed physician. I hereby release Christus Lutheran Church, its pastors, employees, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my son or daughter's involvement.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of Christus Lutheran Church, its pastors, employees, and volunteer workers in the exercise of their best judgment upon the advice of any such medical or emergency personnel.

I agree to release and hold harmless Christus Lutheran Church, its pastors, employees, and volunteer workers from any and all claims, suits, costs, and actions of any kind whatsoever arising from their exercise of the power granted by this authorization. I also acknowledge that I will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider.

Signature of Parent/Guardian: _____ Date: _____

PERSONAL AND MEDICAL INFORMATION

Minor's Personal Information
Name: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Date of Birth: _____ Age: _____
Additional Address: _____
City/State/Zip: _____ Additional Phone: _____

Minor's Health Insurance Information
Insurance Company: _____

Policy Number: _____ Group Number: _____

PLEASE ATTACH A COPY OF THE INSURANCE FORM TO THIS FORM

In Case of Emergency

Parent(s)

Name: _____ Relationship to Minor: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone/Pager: _____

Email: _____

Other

Name: _____ Relationship to Minor: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone/Pager: _____

Email: _____

Minor's Medical Information

Date of Last Tetanus Shot: _____

Minor's Doctor: _____ Phone: _____

Names, dosages, and purpose of medications being taken:

Allergies (medication, food, other) :

Special Considerations (medical conditions, dietary needs/restrictions, activity limitations, etc.):

This personal and medical information is completed and signed by the Parent/Guardian.

Name: _____ Date: _____