

Invert Student Ministries

--Permission Form and Medical Form--

PERMISSION FORM (must be filled out for EVERY event/activity)

Event Name: _____

I give permission for _____ to attend this event/activity.

I give permission to the leader or chaperone to secure a licensed physician in the case of an emergency to provide necessary care.

Parent or Guardian: _____ Date: _____

MEDICAL FORM (must be filled out and returned if not on file with the church)

NOTE:

1. Medical information only needs to be turned in once a year
2. If any information changes, a new Medical Form must be completed.
3. Please check & initial one of the following

_____ This medical information has been turned in to Invert Student Ministries and is accurate.

_____ This is the first time Invert Student Ministries will receive this Emergency Medical information.

Please print legibly and complete both sides of form. All information contained herein will be treated confidentially.

STUDENT'S NAME _____

AGE _____ BIRTHDATE _____ / _____ / _____ CURRENT GRADE LEVEL _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE (____) _____ - _____

FATHER/GUARDIAN _____ WORK (____) _____ - _____ CELL (____) _____ - _____

ADDRESS (IF DIFFERENT THAN STUDENT'S) _____

CITY _____ STATE _____ ZIP _____ PHONE (____) _____ - _____

MOTHER/GUARDIAN _____ WORK (____) _____ - _____ CELL (____) _____ - _____

ADDRESS (IF DIFFERENT THAN STUDENT'S) _____

CITY _____ STATE _____ ZIP _____ PHONE (____) _____ - _____

INSURANCE COMPANY _____ CLAIMS PHONE (____) ____ - _____

GROUP NUMBER _____ POLICY/ID NUMBER _____

STUDENT'S PHYSICIAN _____ PHONE (____) ____ - _____

IS STUDENT CURRENTLY ON ANY MEDICATIONS? (CHECK ONE) NO _____ YES _____ LIST BELOW:

MEDICATION _____ DOSAGE _____ AND PHONE # _____

MEDICATION _____ DOSAGE _____ AND PHONE # _____

DOES THIS STUDENT HAVE ANY ALLERGIES? (CHECK ONE) YES _____ NO _____ EXPLAIN BELOW:

ARE THESE ALLERGIES LIFE THREATENING? (CHECK ONE) YES _____ NO _____ EXPLAIN BELOW:

DOES THIS STUDENT HAVE ANY PHYSICAL, EMOTIONAL, MENTAL OR BEHAVIORAL CONCERNS OR LIMITATIONS THAT OUR STAFF SHOULD BE AWARE OF? PLEASE EXPLAIN BELOW:

EMERGENCY CONTACTS: (IF PARENTS CAN NOT BE REACHED)

NAME _____ RELATIONSHIP _____ PHONE (____) ____ - _____

NAME _____ RELATIONSHIP _____ PHONE (____) ____ - _____

CONSENT FOR MEDICAL TREATMENT

By signing below, the participant (or parent/guardian if participant is a minor) acknowledges and accepts the risks of physical injury associated with participation in the activity described above. Except for gross negligence on the part of the sponsor, the participant (or parent/guardian) accepts personal financial responsibility for any bodily or personal injury sustained during the activity. Further, the participant (or parent/guardian) promises to hold harmless the sponsoring organization and its representatives for any injury related to the activity.

If a dispute over this agreement or any claim for damages arises, the participant (or parent/guardian) agrees to resolve the matter through a mutually acceptable arbitration process.

Signature of Parent or Guardian _____ Date _____

Signature of Parent or Guardian _____ Date _____