

STUDENT MINISTRY PERMISSION SLIP FOR AUGUST 2014 through AUGUST 2015

Medical Release Form/Permission to Treat

Name of Church: The Highlands Church
3678 Cleveland Hwy
Gainesville, GA 30506

Name of Participant: _____
Social Security #: _____
Birthdate: _____ / _____ / _____ Age: _____ Sex (M/F): _____
Address: _____
City: _____ State: _____ Zip: _____
Parent/Guardian: _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Secondary contact to notify in event of emergency: _____
Their relationship to you: _____ Their phone: (_____) _____

Please supply ALL of the following information.

Medical Insurance Co.: _____
Group# _____ Policy#: _____
Company's address: _____
Company's Phone: (_____) _____

Family Physician's Name: _____ Phone: (_____) _____

Attach a copy of your insurance card below.

Physical Limitations (Asthma, diabetes, allergies, etc.), **and/or special instructions** (Allergic to certain meds, rare blood type, wears contact lenses, etc.):

List ALL medication taken on a regular basis and/or any brought with you (Prescription meds MUST have a pharmacy label and name of doctor):

List ALL operations/serious injuries and dates within the past five (5) years:

The Health History is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted.

Emergency Authorization - I hereby give permission to medical personnel selected by the participant's Church sponsor/his designee or camp staff to order X-rays, routine tests, and treatment for _____ (youth's name). In the event of an emergency and neither my primary contact nor secondary can be reached, I hereby give permission to the physician selected by the Authorized Agent to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery to _____ (youth's name). I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release the church, its employees or agents from liability associated with participation in a church activity. I understand that if I do not have medical insurance, I, as the parent or guardian, will be responsible for any medical expenses in the event of a sickness and/or injury. I understand that there are risks involved in taking part in recreation activities and other activities related to participation in youth functions.

Parent/Guardian (Please print name)

Signature of Parent/Guardian

Date

The following to be completed by the notary witnessing parent/guardian's signature.

The State of _____ the County of _____ Before me,
a Notary Public, on this day personally appeared _____ known to me (or proved to me on
the oath of _____) to be the person whose name is subscribed to the
foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration
therein expressed. Given under my hand and the seal of the office this
_____ day of _____, A.D. _____.

Notary Public, Signature

My commission expires the _____ day of _____, A.D. _____.