

# CHRIST UNITED METHODIST CHURCH PERMISSION SLIP

## Personal Information:

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Circle One: Male or Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Email Address \_\_\_\_\_

## Medical Information: Check the appropriate blank if you have ever had any of the following:

\_\_\_\_ Bee/Wasp Reaction      \_\_\_\_ Dizziness or Fainting      \_\_\_\_ Hay Fever      \_\_\_\_ Heart Trouble      \_\_\_\_ Pregnant  
\_\_\_\_ Penicillin Allergy      \_\_\_\_ Physical Disability      \_\_\_\_ Diabetes      \_\_\_\_ Asthma      \_\_\_\_ Epilepsy  
\_\_\_\_ Respiratory Problems      \_\_\_\_ High Blood Pressure      \_\_\_\_ Operation in last year  
\_\_\_\_ Regular Medication (List Below)      \_\_\_\_ Allergies including drug & food (List Below)      \_\_\_\_ Other (Explain Below)

List medications, allergies and other \_\_\_\_\_

## Parent or Guardian Information:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cell# \_\_\_\_\_  
Address (if different) \_\_\_\_\_ Home Phone# \_\_\_\_\_

## Insurance Information:

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_ Preferred Hospital \_\_\_\_\_  
Doctors Name \_\_\_\_\_ Doctors Phone Number \_\_\_\_\_

## In case of Emergency Contact: (Must be different than the address above)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home# \_\_\_\_\_ Cell# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

I certify the information provided is correct to the best of my knowledge. In the event of an emergency, I give permission to the directors of the activity and/or Christ United Methodist Church to render First Aid, as well as permission to a licensed physician to hospitalize, anesthetize, or perform surgery on the person listed. I understand that every reasonable effort will be made to make contact with the above mentioned emergency contact before these actions are taken.

I give permission to the directors of the listed activity and/or Christ United Methodist Church to give the minor child listed above the following medications as needed: 1. Tylenol (Acetaminophen) 325mg/tablet following the directions on the package for pain or fever. 2. Benadryl (Diphenhydramine) 25mg/tablet following the package direction for allergic reaction (e.g. bee sting, ECT,).

I further agree to hold harmless and indemnify the Christ United Methodist Church staff and Christ United Methodist Church from any and all claims for damages arising out of personal injuries sustained by myself/son/daughter/ward during any class time or field trip and I hereby fully and forever release and discharge the Christ United Methodist Church staff and Christ United Methodist Church from any and all said claims.

I understand photographs may be taken of those attending this event and may be used for promotional use within the church.

## If above listed is a minor:

Signature of parent/guardian \_\_\_\_\_ Printed Name \_\_\_\_\_  
Relationship to minor \_\_\_\_\_ Date \_\_\_\_\_

## Above listed person:

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

## Parent Review:

Activity \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_  
Activity \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_  
Activity \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_  
Activity \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_