

Permission Slip & Medical Release Form

Alliance Church Student Ministry

502-21st St N Menomonie WI 54751

Effective until June 2012

*Please fill out one per student

I hereby grant permission for my child to participate in the Alliance Church Middle School/Senior High Youth Group. Should any problems arise concerning the behavior of my child that would require them to return home prior to the end of the activity, I will pay for his or her return or come pick up my child.

I recognize that Alliance Church uses photographs and video images of events in our publicity materials such as the church website, newspapers, and newsletters.

I hereby grant do not grant permission for photo/video images of my child to be taken and used for such purposes.

My child may be given acetaminophen, ibuprofen, or Sudafed by the Adult Leadership (Pastor Kyle) as needed unless otherwise indicated in the Special Medications Section.

I authorize treatment, by a qualified and licensed medical doctor, of the minor listed above in the event of any medical emergency which, in the opinion of the attending physician, is necessary and I/we cannot be reached after reasonable effort has been made to secure my personal consent.

Any medical expenses are the responsibility of the participant and their insurance carrier.

I, the parent/guardian of the registrant, a minor, recognize the possibility of physical injury associated with Alliance Church Student Ministries. Inconsideration for DFC accepting the registrant for its programs and activities, I hereby release, discharge, and/or otherwise indemnify DFC, its employees and associated personnel, including the owners and directors of facilities utilized for the programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the programs and/or being transported to or from the same, which transportation I hereby authorize.

Signed: _____ (parent or legal guardian)

Date: _____

Student's Name: _____

Grade in Fall 2011: _____

Date of Birth: _____

Home Phone: _____

T-shirt size: _____

Street Address: _____

City: _____ State: _____ Zip: _____

CONTACTS:

Parent/Guardian: _____

Work Phone: _____ Cell: _____

Parent Guardian: _____

Work Phone: _____ Cell: _____

EMERGENCY CONTACTS:

Name: _____

Relationship: _____

Phone V : _____

Name: _____

Relationship: _____

Phone V _____

MEDICAL INFORMATION:

Medical Insurance Co: _____

Policy #: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Date of Last Tetanus shot: _____

Special Medical Conditions: Allergies, Chronic Illness, or other conditions/instructions:

Current Medications:

Any other information (special needs, concerns):