Children and Youth Ministries Event Permission Slip

I hereby give my permission for _____ (name of youth/child) to participate in the event designated below. I understand that reasonable plans have been made to ensure the safety and welfare of all participants, and that adult employees or volunteers will be chaperoning at the event and will take reasonable actions as they deem necessary to protect the best interests of all participants. I understand and agree that if my child is not behaving in a manner consistent with church standards for good conduct, is not following event rules or is being disrespectful to adults in charge of the event, my child may not be allowed to continue participating in the event and I may be asked to pick up my child. I release and waive any liabilities against the Event Sponsor and/or Texico Conference Association of Seventh-day Adventists, its employees and volunteers arising out of my child's participation in the event designated below, and I further agree to indemnify the Event Sponsor and/or the Texico Conference Association of Seventh-day Adventists, its employees and volunteers, for any and all damage or injury that my child may cause as a result of his/her participation in the event.

Upcoming Event/Trip To _____

Date of Event/Trip _____ Cost _____

Event Sponsor _____

Parent/Guardian Signature _____

Parent/Guardian Printed Name _____

Date _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Emergency Contact _____ Phone Number _____

_____ (please initial) I give my permission for the Event Sponsor to use pictures taken at the above event that include my child in Sponsor publications or promotional materials.

Medical Release Form

I, _____ the parent/legal guardian of

_____ (name of youth/child), hereby authorize Event Sponsor employees or volunteers to administer first aid or seek emergency care for my child if necessary. Furthermore, I authorize any necessary medical care or medical procedures to be performed for my child by a licensed physician or hospital when deemed necessary or advised by a physician to safeguard my child's health in the event that I cannot be contacted. I waive my right of informed consent for such treatment. I understand that I will be responsible for any medical expenses occurring as a result of such treatment.

Parent/Guardian Signature _____

Parent/Guardian Printed Name _____

Date _____

Child's Date of Birth _____

Doctor _____ Phone _____

Insurance Provider _____

Insurance ID/Group No. _____

Primary Policy Holder _____

Allergies _____

Medication Currently Taken _____

Any Present Health Concerns? _____

_____

_____

Date of Last Tetanus Shot _____