Cornerstone Church Permission Slip

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CONSENT AND RELEASE FROM LIABILITY

____ has my permission to participate in the following activities of Cornerstone Church ____ on __________________ (date) and to be transported by church vehicle or private car when necessary. In consideration of the benefits to be derived from these activities, I hereby voluntarily waive any claim against Cornerstone Church, the sponsors, and the owner/or driver of the car or church vehicle furnishing transportation to this event. I further agree to direct my son/daughter to conform to the fullest with the directions and instructions of the sponsors in charge. I also understand that no drinking, smoking, sexual conduct or use of drugs is permitted on this church trip and that a violation of any of these will result in the immediate return home, at my expense.

Parent/Guardian signature:______________________________ Phone: (______)________________

Street: _____________________________ City: ______________________ Zip: ____________

CONSENT TO TREAT A MINOR

Being the parent or legal guardian of above mentioned youth(s) I do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child(s). Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child(s). I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.
Further, as parent or legal guardian I am responsible for the health care decisions for my minor child(s) and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child.
Primary Physician Name:______________________________ Phone number: __________________

Health Insurance Name: ______________________________ Policy number: __________________

MEDICATION

Are you bringing any medications with you? [ ] NO [ ] YES (list on back of form)
If YES, PLEASE LIST EACH MEDICATION ON THE BACK OF THIS FORM ALONG WITH THE SCHEDULE AND DOSAGE.
All medications must be in their original containers (even aspirin and over-the-counter medications). Each must contain the patient's name, original orders, dosage, dates, and directions for use and specifics for storage (i.e. refrigeration).

IT IS THE RESPONSIBILITY OF PARENT/GUARDIAN TO INSURE THAT THEY CAN BE CONTACTED IN THE EVENT OF AN EMERGENCY.