

# PERMISSION SLIP

Event: \_\_\_\_\_ Sponsor Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL RELEASE:** I, \_\_\_\_\_, the undersigned parent or person having legal custody or the legal guardian of above named minor give permission for the above named minor to participate in the above activity at FBC Pearland and do hereby authorize the sponsor to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician, surgeon, or dentist licensed under the laws of the state they practice in. In giving this consent I recognize and understand that in situations where the named minor requires immediate medical or hospital care it may not be possible to contact me, in such situation I will not be able to knowledgeably evaluate and chose among the available alternative treatments or procedures, if any, or to evaluate the risk attenuate upon each, and the risk attenuate to forgoing all treatment in such situations, I authorize a physician, surgeon, or dentist to exercise his professional judgment and assess the risk incident to and chose the necessary treatment from any available alternatives and to render such care and perform such treatment as he in his professional judgment determines to be necessary for the health or safety of the above named minor. I also agree to reimburse any expenses not covered by the church's insurance. I will not hold the church or any of the workers responsible for any illness or injury to my child.

\_\_\_\_\_  
(Signature of parent or legal guardian)

\_\_\_\_\_  
(date)

## Medical Information

Medical Insurance Provider: \_\_\_\_\_ Policy Number \_\_\_\_\_

Any health problems, limitations, etc: \_\_\_\_\_  
\_\_\_\_\_

Any allergies, or medicines, drugs, or shots person is allergic to: \_\_\_\_\_  
\_\_\_\_\_

Is your child bringing any medication to this event? (Medications must be labeled as to the contents and your child's name) \_\_\_\_\_  
\_\_\_\_\_

If Yes, give name of medication(s) and directions for administering: \_\_\_\_\_  
\_\_\_\_\_



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