St. Mark's Lutheran Church

Events Form

Permission Slip and Photo Release

Today's Date_____

Participant's Name_____ Birth Date_____ Gender_____

Home Address_____ Age _____ Grade (as of date on form) _____

City _____ State _____

Zip Code _____

Does participant attend church? _____

If so, where? _____

Please print clearly in ink and use a separate form for each participant. The information on this form, but is gathered to assist us in identifying appropriate care of participants. This form must be filled out by parents/guardians of minors. An update is required annually.

Parent or Guardian Name(s) _____

Phone numbers where you can be reached during the day (please circle best number to call)

Home # _____ Work # _____

Cell # _____

Home Address (if different than participant address)

_____ Email address _____

Emergency Contact (other than above) _____

Daytime Phone _____

Relationship to participant _____Is participant covered by medical/hospital insurance?

Yes_____ No _____

If yes, please indicate carrier plan or name _____

Group Number _____

Parent/Guardian Photo Authorization:

I give St. Mark's Lutheran church and any individual acting as its agent permission to use photography/ video of myself/my child taken on St.Marks' outings/events.

Signature of parent/guardian_____

Date_____

St. Mark's Lutheran Church Events Form

Medical Information/Release

Allergies - Please list all known allergies

Medication Allergies

_____

Describe reaction and management of reaction

_____

_____

Food Allergies

_____

Describe reaction and management of reaction

_____

_____

Other Allergies

_____

Describe reaction and management of reaction

_____

_____

Current Medications _____

Reason (s) for taking _____

_____

Medical Conditions: Does the participant have any medical conditions of which the St. Mark's event leaders should be aware? Please use this space to describe.

_____

_____

_____

_____

_____

Restrictions The following restrictions apply to this individual. Please explain any activity restrictions (i.e. what cannot be done, what adaptations or limitations are necessary)

_____

_____

_____

_____

Additional Information

Please use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the St. Mark's leaders/chaperones should be aware. The better informed the event leaders can be, the better they will be able to provide for the needs of your child.

_____

_____

_____

_____

_____

_____

Family Doctor _____ Phone _____

Address _____

City _____ State _____ Zip _____

Family Dentist/Orthodontist _____ Phone_____

Address _____

City _____ State _____ Zip _____

Parent/Guardian Authorization:This health history is correct and complete as far as I know. The person herein described has permission to engage in all St. Mark's activities except as noted. I hereby give permission to the St. Mark's leaders/chaperones to provide routine health care and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for medical treatment, referral, billing or insurance purposes. I give permission to the St. Mark's leaders/chaperones to arrange necessary related transportation for me/my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the St. Mark's leaders/chaperones to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian or adult participant_____

Date _____