Discovery Student Ministries

Permission Slip and Medical Release Form

Effective until May 2016

*Please fill out one per student

Student's Name: _____

Parent Name(s):_____

Street Address: _____

City: _____State: ____ Zip: _____

Grade in Fall 2015:_____Date of Birth: _____

t-shirt size (adult sizes) S, M, L, XL

I hereby grant permission for my child to participate in the Discovery Fellowship Church Middle School/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 Discovery Fellowship Church uses photographs and video images of events in our publicity materials such as the church website, photo walls, and newsletters and I hereby grant permission for photo/video images of my child to be taken and used for such purposes.

My child may be given acetaminophen, ibuprofen, Sudafed, or other basic medical needs by the Adult Leadership as needed.

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 Discovery Fellowship 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: _____ Date:_____

(parent or legal guardian)

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Home Phone: (____)_____ Mother's Cell Phone: (___)_____

Work Phone: (____) _____ Father's Cell Phone: (___)_____

Emergency Contacts:

1. Name: _____ Relationship to Student: _____
   Day Phone: (___) _____ Night Phone: (___) _____
2. Name: _____ Relationship to Student: _____
   Day Phone: (___) _____ Night Phone: (___) _____

Medical Information:

Medical Insurance Co: _____

Policy #: _____

Primary Care Physician: _____

Address: _____

City: _____State: _____Zip:_____

Telephone Number: (___) _____

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

_____
_____
_____
_____

Current Medications:

_____
_____
_____

Date of Last Tetanus shot: _____

Any other information (special needs, concerns):

_____
_____
_____
_____