PERMISSION AND MEDICAL FORM

Our Saviour Lutheran Church

THIS FORM MUST BE COMPLETED BY ALL PARTICIPANTS.

Name of Participant: _____

Participant's Date of Birth (mo/day/yr): _____

Medical Insurance Carrier: _____

Policy / Contract Number: _____

Allergies / Disabilities / Special Medical Conditions, Food Needs, or other concerns of which event leaders should be aware:

_____

_____

Medications: _____

Is your child able to responsibly self medicate:_____

I give permission for my child to be treated if I am unable to answer any messages: (please sign:)

_____

Emergency Contact Information

Name: _____ (relationship: _____)

Daytime phone: (_____) _____

Nighttime phone: (_____) _____

Secondary Contact: Name: _____ Relationship: _____

Daytime phone: (_____)_____ Nighttime phone: (_____)_____

Parents / guardians of participants under 18 must complete this section:

• In the event I cannot be reached at the numbers above, I give permission to have the above participant treated at an appropriate medical facility as deemed necessary.

Signature of Parent_____