

**Calvary Chapel Tustin
Youth Ministry**

Permission Slip

(PLEASE PRINT CLEARLY)

Youth's Name: _____ Date of Birth: _____
Age: _____ Current Grade: _____ Sex (M/F): _____
Complete Home Address: _____
Home Phone Number: _____
Emergency Phone Number: _____

Church Activity: _____ **Activity Date:** _____

I, _____ (*printed name of parent/guardian*) being the parent or legal guardian of _____ (*printed name of minor*) have been informed of the above activity sponsored by Calvary Chapel Tustin and hereby give my consent for my minor child to participate in this activity.

I understand that all reasonable safety precautions will be taken by the leaders of this activity, and that the possibility of an unforeseen hazard does exist. I further agree not to hold Calvary Chapel Tustin, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the minor listed on this form.

I also understand that my minor child is to be excluded from the following activities:

Signature of parent/guardian: _____ Date signed: _____

Parent Consent to Treat a Minor

Being the parent or legal guardian of _____, (*minor's name printed*) I _____ (*parent/guardian's name printed*) do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. 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. 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 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. Any policy of the church or organization sponsoring this event will be used as the secondary coverage.

Medicine/allergies: _____
Name of family physician or medical group: _____
Phone number of physician or medical group: _____

Signature of parent/guardian: _____ Date signed: _____