GRACE PCA

Parental Permission Form

Student's/Participant's Name____

Age____________________ Birthday____

Address____

School____ Grade__________________

Parent/Guardian's Name (print)____

Home Phone________________ Work Phone_________________ Cell Phone__________________

Emergency Contact (in case you are unavailable)

Name____

Relation____ Phone___________________________

I, ______________________________, parent/guardian of ___________________________, hereby give approval for his/her participation in any and all GRACE PCA activities from January 1, 20_____ through December 31, 20_____. I assume all risks and hazards incidental to such participation, including transportation to and from the activities, and do hereby, waive, release, absolve, indemnify, and agree to hold harmless GRACE PCA, its agents, employees, sponsors, supervisors, participants and persons transporting the participant to and from activities, for any claim arising out of injury to the participant. I also understand that GRACE PCA does not assume any responsibility for loss of, or damage to, personal property of the participant.

Parent/Guardian's Signature____

Date_______________________________________

Medical Release

In the case of an emergency, I hereby give my permission to the sponsors of this event to permit hospital personnel and/or a licensed physician to perform emergency treatments and administer drugs in conjunction with such emergency treatment. I understand that the sponsors of each event will determine whether emergency care is necessary and will arrange for such services to be provided.

Parent/Guardian's Signature____

Date_______________________________________

Medical and Insurance Information

List any allergies____

Does participant have asthma?____________If so, does he/she use an inhaler?_______________
If yes, will it be with him/her?____________

Any medications participant routinely takes?____

I give my permission for an adult youth ministry leader to give over-the-counter medications I have circles:

Tylenol Ibuprofen Antihistamine Decongestant Other_____________

Please inform us of any changes in your child's medical history.

Family Physician____________________________ Office Number_________________

Insurance Company__________________________ Policy #_______________________