

# TRIP PERMISSION SLIP & MEDICAL CONSENT FORM

Parents: Please complete and return as soon as possible.



**Child's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  M  F

**Address:** \_\_\_\_\_

**Event:** \_\_\_\_\_ **Event Location:** \_\_\_\_\_

**Event Date(s):** \_\_\_\_\_ **Cost:** \_\_\_\_\_ **Transportation:** \_\_\_\_\_

**Departure:** **Meetup:** \_\_\_\_\_ **am/pm** **Depart Time:** \_\_\_\_\_ **am/pm** **Location:** \_\_\_\_\_

**Arrival:** **Arrival Time:** \_\_\_\_\_ **am/pm** **Location:** \_\_\_\_\_

**Sponsor/Club:** \_\_\_\_\_

**Permission to Travel**

My child has my permission to go on the aforementioned trip. I understand the arrangements and give permission for my child to attend. I also agree to indemnify and hold harmless the Washington Conference of Seventh-day Adventists, its employees, representatives, agents and sponsors from liability arising from any accident or injuries occurring during this trip, including any injury due to negligence on the part of those mentioned above. This does not include gross negligence on the part of those mentioned above, nor does it waive coverage within the policy limits of church accident insurance, which covers church-sponsored activities. This permission recognizes the shared responsibility amongst the church, student and home.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)

**Permission to Treat**

I hereby give permission to the medical provider selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injections or surgery for my child. A photo copy of this shall be as valid as the original.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)

Please check if any of the following apply:

\_\_\_\_\_ My child needs medication.

*(Parent/guardian is required to furnish medication in the original, properly labeled and correctly authorized container.)*

\_\_\_\_\_ My child is allergic to insect bites to the extent that he/she needs medical treatment.

\_\_\_\_\_ My child is allergic to (medications or other): \_\_\_\_\_

\_\_\_\_\_ My child has special dietary requirements: \_\_\_\_\_

\_\_\_\_\_ My child has other special conditions you should be aware of, listed on the back of this form.

**During the trip, I can be reached at the following number(s):**

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Mother's Phone: \_\_\_\_\_ (home)

Father's Phone \_\_\_\_\_ (home)

Mother's Phone: \_\_\_\_\_ (work)

Father's Phone \_\_\_\_\_ (work)

Mother's Phone: \_\_\_\_\_ (cell)

Father's Phone \_\_\_\_\_ (cell)

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_