Grace Crossing United Methodist Church

PARENTAL PERMISSION
FOR FIELD TRIP OR CHURCH ACTIVITY

This is to certify that my child _____ has my permission to attend Grace Crossing United Methodist Youth field trips and activities.

In addition, I understand and agree to the following statements:

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1. I give permission for my child to travel in a Grace Crossing United Methodist Church van or adult leader-driven vehicle during the activity.

2. I hereby release Grace Crossing United Methodist Church and all adult leaders from any liability and from any and all claims against them, individually or collectively, for any injuries that might be received during youth activities, field trips, or in traveling to and from such activities or field trip destinations.

Parent/Guardian Signature:_____ Date:_____

Address:_____ **Emergency Contact Phone Numbers**

_____ **Primary:_____**

_____ **Secondary:_____**

Permit must be returned to participate in youth activities:

Direct any questions to:
Adrienne Anderson, Director of Family Ministries, (936) 240-9821
Kristen Ray, Assistant Director of Family Ministries, (603) 785-1077

Important: Please fill out and sign both sides of this permission slip if you want your child to participate in church youth activities.

AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT
OF A MINOR STUDENT

Name of student: _____

Date of birth: _____ Grade: _____

Name of parent or guardian: _____

Address: _____ Home Phone: _____

Father's Cell / Work Phone: _____ Mother's Cell / Work Phone: _____

Friend or relative who may be contacted in the event parents may not be reached:
Name: _____ Phone Number: _____
Relationship: _____

Family Physician: _____ Office Number: _____
Allergies: _____ Last Tetanus: _____
Pertinent medical information: _____

The following scheduled or emergency medication is necessary for my child during this activity:

Note: Only medications sent to the church in the original container with written parent permission may be given. The Youth Director or assigned leader is responsible for administering medications.

Check one:
I ( ) do ( ) do not have medical insurance and I shall assume financial responsibility for any medical treatment of my child.

Insurance Company: _____
Insurance Address: _____
Policy No.: _____Group No. _____
Phone Number: _____

This is to certify that I authorize a designated representative of Grace Crossing United Methodist Church to secure any and all emergency medical care and treatment for my child _____for acute illness suffered or injury sustained while at church or at a hospital clinic or medical facility or by a licensed physician or dentist with the following exceptions:

Parent Signature:_____ Date:_____