

FELLOWSHIP AT FIELD STORE STUDENT PERMISSION SLIP/MED RELEASE FORM

30402 FM 1488, Waller, TX 77484 (936)372-9465

PLEASE PRINT EXCEPT FOR SIGNATURES

STUDENT'S FULL NAME _____ **PHONE** _____

ADDRESS _____ **ZIP** _____

School _____ **Grade** _____

Male _____ **Female** _____ **Birth date** _____

FATHER'S NAME _____

PHONE h _____ w _____ **cell/pager** _____

MOTHER'S NAME _____

PHONE h _____ w _____ **cell/pager** _____

If parents cannot be reached:

NAME _____ **RELATIONSHIP** _____

PHONE h _____ w _____ **cell/pager** _____

Medical Information

If you answer "yes" to any of the following questions, please explain/list all on the reverse of this form.

- 1. Does Youth have any known allergies (including food)? _____ yes _____ no
(if yes, please list all known allergies on reverse)
- 2. Is Youth allergic to any known medications? _____ yes _____ no
(if yes, please list all on reverse)
- 3. Does your Youth take any medicines regularly? _____ yes _____ no
(if yes, please list all on reverse)
If yes do you give permission for youth to administer his/her medication? _____ yes _____ no
- 4. Is your Youth under a physician's care at this time? _____ yes _____ no
(if yes, you will need to provide a statement explaining medication, special diet, restrictions to activities, etc.)
- 5. In Case of Emergency, please check one: _____ Call before treatment is given. _____ Give First Aid, then call.
- 6. Immunizations (list dates) DPT/Tetanus _____ Polio _____ MMR _____ TB _____

HOSPITAL INSURANCE **yes** **no** **INSURANCE COMPANY** _____

PHONE # _____ **POLICY #** _____ **GROUP #** _____

FAMILY PHYSICIAN _____ **PHONE** _____

DENTIST _____ **PHONE** _____

I, _____, as parent/guardian of _____, a minor, hereby acknowledge that said minor is presently under my care, custody, and control. I give my child permission to attend/participate in all activities sponsored by The Fellowship at Field Store. I release The Fellowship at Field Store, its agents, and employees, from any claims or causes of action arising from or connected with transportation to and from such activities as sponsored by The Fellowship at Field Store.

I further agree that information given above s complete and accurate.

I further agree that The Fellowship at Field Store it's agents, or employees, are authorized to provide such medical care treatment as may be necessary, in their judgment, during such transportation and activity. I also agree not to hold The Fellowship at Field Store, staff, group leaders, sponsors, or workers responsible for any harm, danger, accident, or loss of life that may occur. And I will assume responsibility for any medical and transportation expenses.

PARENT SIGNATURE _____ **DATE** _____

**THE INFORMATION ON THE BACK OF THIS FORM
MUST BE COMPLETED AND SIGNED BY ALL PARTIES.**

RULES/EXPECTATIONS

- Students are expected to obey Mission Trip/VBS Leaders without question or hesitation.
- After lights out you are expected to remain in your room except to use the bathroom.
- Rooms must be kept clean and respect must be given to Host's equipment and facilities. Students and their parents are financially responsible for damage to property.
- Students are not to leave the property or the group under any circumstances unless given permission by Pastor John, Mr. Noel, Mrs. Chivvis or a designated group leader and must sign out in the accountability folder.
- Students are responsible for their own things. Do not bring valuables.

PARENT STATEMENT

I have read, explained, and reinforced the rules to my student. I understand that it is my Student's responsibility to obey these rules for his/her own safety and the safety of the group. I realize that I will be responsible for any damages that may be caused by my student. I further understand that if the Mission Trip Staff decides that my child should be sent home that I am responsible for transportation.

SIGNATURE _____ **DATE** _____

STUDENT'S AGREEMENT

I have read these rules and agree to obey them during the Mission Trip for my own safety and the safety of others.

STUDENT SIGNATURE _____ **DATE** _____

Medical Information

If you answered "yes" to any of the medical questions on the front of this form you must explain/list all yes answers below.
