Please fill out both sides of this form.

CONFIDENTIAL

(Form will be held in secured storage by church administrator)

GENERAL PERMISSION SLIP FOR THOSE UNDER THE AGE OF EIGHTEEN
2008-09 EMERGENCY TREATMENT, MEDICAL RELEASE, HISTORY FORM
SILER PRESBYTERIAN CHURCH
6301 Weddington Monroe Road, Wesley Chapel, NC 28104
704-821-7445

___________________________________, age _____ has my permission to be transported in church provided transportation and to participate in the various church related trips, activities, and ministries. In the event of an accident or illness that requires a doctor's care and hospitalization while participating in any church related trip, activity, or ministry whether local or out of town, I understand every effort will be made by leaders to contact the parents, guardians, or next of kin of the above listed individual. In the event contact cannot be made, be it advised that the adult group leader, driver(s), chaperone(s), or church staff member(s), under medical advisement has my permission to ensure his/her well-being. In consideration of the benefits derived, and in view of the fact that Siler Presbyterian Church is a religious institution, membership is voluntary and having full confidence that every precaution will be taken to ensure safety and well-being of my son/daughter on these activities, I agree to his/her participation and waive all claims against the leaders of these trips or events, Siler Presbyterian Church and it's staff.

_______________________________________ ________________

Parent or Guardian's Signature **Date**

Please fill out the information below AS COMPLETELY AS POSSIBLE about the participant.

Name: ____________________________ Date of Birth: __________ SSN: _______________

Address: ____

Phone no. __________________________ E-mail address: ____________________________

School: ____________________________ Grade: _________________________________

Mother's Name: _____________________ Father's Name: ____________________________

Address: ___________________________ Address: _________________________________

___________________________ ___________________________________

Daytime Phone: _____________________ Daytime Phone: ____________________________
Evening Phone: _____________________ Evening Phone: ____________________________
Cell Phone: ________________________ Cell Phone: _______________________________
E-Mail: ____________________________ E-mail: ___________________________________

Medical Insurance Company: ________________________ Policy/ Group Number____________

Name of Insured: ____________________________ Ins. Phone Number: __________________

Name of Physician: __________________________ Phy. Phone Number: __________________

Please fill out both sides of this form

Health History – please check and include date and notes where appropriate

Allergies:	Dates	**Chronic or Recurring Illness**	Dates
Hay Fever	________	Asthma	________
Food (specify)	________	Ear Infections	________
Insect Stings (specify)	________	Diabetes	________
Plants (specify)	________	Convulsions	________
Drugs (specify)	________	Heart Disease	________
Other (specify)	________	Kidney	________

Notes

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Other (Specify) ____

Medication presently being taken ____

Date of Last Tetanus Shot ____

Over the counter medication authorization: I hereby give permission for my son /daughter to use the following over the counter medications (OTC) and/or their generic equivalents as directed on the label. (Check yes or no for each medication)

Medication		Medication	
Advil (Ibuprofen)	__ Yes __ No	Cough Drops	__ Yes __ No
Aspirin	__ Yes __ No	Dramamine	__ Yes __ No
Bactine	__ Yes __ No	Maalox	__ Yes __ No
Benadryl (oral)	__ Yes __ No	Neosporin	__ Yes __ No
Benadryl (topical)	__ Yes __ No	Pepto- Bismol	__ Yes __ No
Caladryl	__ Yes __ No	Sudafed	__ Yes __ No
Cortaid	__ Yes __ No	Tylenol (Acetaminophen)	__ Yes __ No
Claritin	__ Yes __ No		

Please list any additional OTC medications your child may not have: ______________________

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Emergency Authorization: I hereby give permission to the medical personnel selected by the Siler Presbyterian Church adult in charge to order X-Rays, routine tests, and treatment for my child, and in the event I can't be reached in an emergency, I hereby give permission to the physician selected by the adult in charge to hospitalize, secure proper treatment for, and to order injection and/or surgery for my child as named above.

If I/We cannot be reached in the event of and emergency, the following person is authorized to act in my behalf:

____

Name Relationship Phone

I know of no reason(s), other than the information on this form, why my child should not participate in Siler Presbyterian Church program Activities. I acknowledge that the information on both sides of this form is correct, and I will inform Siler Presbyterian Church if any part of this information changes.

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Parent/Guardian Signature Print Name Date