

**nyi @ warren first**  
**:: student ministries ::**

**PERMISSION SLIP** (MUST BE FILLED OUT FOR EVERY ACTIVITY)

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**Event Name:** \_\_\_\_\_ **Event Date:** \_\_\_\_\_

I, \_\_\_\_\_, the parent and/or legal guardian of

\_\_\_\_\_ (said minor) born on \_\_\_\_\_  
allow said minor to participate in the above 'said activity' with the **NYI @ Warren First Church of the Nazarene**, including transportation if applicable, sponsored by Warren First Church of the Nazarene, a nonprofit corporation located at 4179 Parkman Road NW, Warren, Ohio, 44481.

I recognize the possibility of physical injury associated with 'said activity,' and for Warren First Church of the Nazarene accepting said minor to participate in 'said activity,' I hereby release, discharge, and/or other wise indemnify Warren First Church of the Nazarene, its' affiliated organizations, sponsors, employees, and associated personnel, against any and all claims by or on the behalf of the minor as a result of the minor's participation in the above referenced 'said activity.'.

Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Emergency Contact – Name, Relationship & Phone Number \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL FORM** (MUST BE FILLED OUT AND TURNED IN IF NOT ON FILE WITH CHURCH)

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**PLEASE NOTE THE FOLLOWING:**

1. Medical information only needs to be turned in once for the calendar year (January – December 2007).
2. **If ANY "Medical Form" information changes a new "Medical Form" must be completed.**
3. Please check and initial one of the following:

\_\_\_\_\_ Medical information has been turned into the NYI @ Warren First Church and is current. (Stop Here)

\_\_\_\_\_ This is the first time the NYI @ Warren First will receive Emergency Medical Information. (Continue Filling Out)

*Please print legibly and complete both sides of form. All information contained herein will be treated confidentially.*

DATE \_\_\_\_\_

STUDENT NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ CURRENT GRADE LEVEL \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

FATHER/GUARDIAN \_\_\_\_\_ WORK PHONE \_\_\_\_\_

STREET ADDRESS (IF DIFFERENT THAN STUDENT'S) \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

MOTHER/GUARDIAN \_\_\_\_\_ WORK PHONE \_\_\_\_\_

STREET ADDRESS (IF DIFFERENT THAN STUDENT'S) \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

FATHER'S CELL PHONE \_\_\_\_\_ MOTHER'S CELL PHONE \_\_\_\_\_

EMERGENCY CONTACTS (IF PARENTS' CAN NOT BE REACHED)

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

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INSURANCE COMPANY \_\_\_\_\_ CLAIMS PHONE \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_ POLICY/ID NUMBER \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_ RELATIONSHIP TO MINOR \_\_\_\_\_

STUDENT'S PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

IS STUDENT CURRENTLY ON ANY MEDICATIONS? (CHECK ONE) YES \_\_\_\_\_ NO \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_ PHONE \_\_\_\_\_

SPECIAL INSTRUCTIONS \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_ PHONE \_\_\_\_\_

SPECIAL INSTRUCTIONS \_\_\_\_\_

DOES THIS STUDENT HAVE ANY ALLERGIES? (CHECK ONE) YES \_\_\_\_\_ NO \_\_\_\_\_ EXPLAIN BELOW:

\_\_\_\_\_  
\_\_\_\_\_

ARE THESE ALLERGIES LIFE THREATENING? (CHECK ONE) YES \_\_\_\_\_ NO \_\_\_\_\_ EXPLAIN BELOW:

\_\_\_\_\_  
\_\_\_\_\_

DOES THIS STUDENT HAVE ANY PHYSICAL, EMOTIONAL, MENTAL OR BEHAVIORAL CONCERNS OR LIMITATIONS THAT OUR STAFF SHOULD BE AWARE OF? PLEASE EXPLAIN BELOW:

\_\_\_\_\_  
\_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT**

I, \_\_\_\_\_, the parent and/or legal guardian of

\_\_\_\_\_ (said minor) born on \_\_\_\_\_

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I do hereby authorize, consent and permit the rendering of general, necessary medical, dental, and/or surgical care or treatment for the benefit of said minor as fully and with all intent and purposes as I would do if personally present.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness