

Please fill out both sides of this form

9/05

# CONFIDENTIAL

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

**GENERAL PERMISSION SLIP FOR THOSE UNDER THE AGE OF EIGHTEEN  
2007-08 EMERGENCY TREATMENT, MEDICAL RELEASE, HISTORY FORM  
SHARON UNITED METHODIST CHURCH  
4411 Sharon Road, Charlotte, NC 28211  
704-366-9166**

\_\_\_\_\_, 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 Sharon United Methodist Church is a religious institution, membership in which 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, Sharon United Methodist Church and its 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**

<b>Allergies:</b>	<b>Dates</b>	<b>Chronic or Recurring Illness</b>	<b>Dates</b>
Hay Fever	_____	Asthma	_____
Food (specify)	_____	Ear Infections	_____
Insect Stings (specify)	_____	Diabetes	_____
Plants (specify)	_____	Convulsions	_____
Drugs (specify)	_____	Heart Disease	_____
Other (specify)	_____	Kidney	_____

Notes \_\_\_\_\_  
\_\_\_\_\_

Other (Specify) \_\_\_\_\_

Medication presently being taken \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_ (Year will suffice)

**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.)

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: \_\_\_\_\_  
\_\_\_\_\_

**Emergency Authorization:** I hereby give permission to the medical personnel selected by the Sharon United Methodist 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 anesthesia and/or surgery for my child as named above.

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

<b>Name</b>	<b>Relationship</b>	<b>Phone</b>
-------------	---------------------	--------------

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

Parent/Guardian Signature	Print Name	Date
---------------------------	------------	------