

LEROY COMMUNITY CHAPEL

12920 PAINESVILLE-WARREN RD. PAINESVILLE, OH 44077 (440) 254-4747

PERMISSION SLIP FOR YOUTH EVENT

I hereby give my permission for my son / daughter _____ to participate in

_____.

Residential Parent or Guardian:

Mother: _____ Father: _____
 First Last First Last

Address: _____

I can be reached at the following phone numbers: _____

Child's Address: _____

Child's Birth date: _____ Church: _____

Group Leader: _____

GENERAL HEALTH INFORMATION FOR MY CHILD

Any allergies or illness: _____

Taking any medication: _____

Wearing glasses? _____ Contact Lenses? _____

Approximate time of last tetanus injection: _____

Insurance Company: _____ Policy #: _____

To the best of my knowledge, the above health information is correct and the above named person has my permission to engage in all activities unless otherwise stated. In the event of an emergency and I cannot be reached, I hereby give permission to the physician selected by the event director to secure proper treatment for my child.

Date

Signature of Parent

(PLEASE COMPLETE THIS PORTION OF THE FORM ONLY IF YOU ARE TAKING MEDICATION.)

**PARENTS REQUEST FOR THE ADMINISTRATION OF MEDICATION
BY STAFF PERSONNEL**

I hereby authorize, request, and give my consent to the Leroy Community Chapel or other responsible person, to store, supervise, and/or administer the following medication to my teen.

Prescribed Medication _____
(Doctor's Written Note Attached)

Non-Prescription Medication _____

Name of Teen: _____

Address: _____

Name of Medication, Dosage, and Route of Administration: _____

Time of Day to be Administered: _____

Date to Begin Medication: _____

Date to Complete Medication: _____

It is impossible to arrange for this medication to be taken at home, therefore it must be administered during the retreat. Yes _____ No _____

Please regard my signature below as my assurance that I release Leroy Community Chapel and Medical Staff from any liability or damages resulting from the consequences of or adverse reaction of our teen's taking or failing to take this medication at the times prescribed. I also agree to keep the church informed in writing of any revision in the physician's prescription. I have had the opportunity to ask any questions. They have been fully answered to my satisfaction.

Date

Signature of Parent or Guardian