2018-2019

PERMISSION TO ATTEND/ AUTHORIZATION FOR MEDICAL TREATMENT

Lutheran Church of Dell Rapids

701 Orleans Avenue Dell Rapids, SD 57022
605-428-3197
Church e-mail: lcdr@siouxvalley.net

Please print and return completed form to church office.

_____ has my permission to participate in all activities of the Lutheran Church of Dell Rapids and
(child's full name, please)
to be transported by Church van or private car when necessary. I understand all events will have adult supervision. In consideration of the benefits to be derived from these activities, I hereby voluntarily waive any claim against the Lutheran Church of Dell Rapids, the sponsors, and the owner/or driver of the car or van furnishing transportation to any event. I further agree to direct my son/daughter to conform to the fullest with the directions and instructions of the sponsors in charge. This consent and release is in effect until I give the Lutheran Church of Dell Rapids written notice to the contrary.

Parent/Guardian: _____

Street:_____ City:_____ Zip:_____

Home Phone:(____)_____ Work (list all): _____

Cell Phone (list all):_____

E-mail (list all): _____

PERSONAL INFORMATION:

Child's Birthdate:_____ Baptismal Date:_____ Child's current grade in school_____
mm dd yy mm dd yy

____Yes ____ No, I give permission to post appropriate pictures of my child on the website or church related publications.

MEDICAL CARE PERMIT

Medical Information is considered confidential and is shared with staff and volunteers on a need to know basis.

I hereby authorize emergency medical care or first-aid treatment as needed for _____ in the
(child's name)
event of illness or injury during any sponsored activity of the Lutheran Church of Dell Rapids. This permit is in effect until I give the Lutheran Church of Dell Rapids written notice to the contrary.

Health Insurance Company:_____ Subscriber's name:_____

Policy Number: _____ Insurance company's emergency phone:_____

Primary Doctor & Phone: _____

Nearest Relative as Emergency Contact: Name_____ Phone _____

Has he/she had any surgery or serious illness within the last 3 years? ____yes ___no.

If yes, explain: _____

Is he/she required to take any medication? ___yes ___no. If so, what medication and for what reason?

_____

Does he/she have any allergies or allergic reaction to any medication or food? ___yes ___no.

If yes, explain:_____

Is he/she presently under a doctor's care? ___yes ___no. If yes, explain: _____

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

___ **Yes, medical or family information has changed since previous form.**