

**Permission Slip**

**LONGVIEW COMMUNITY CHURCH**

2323 Washington Way  
Longview, WA 98632  
(360) 423-6380

**Name of Student** \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Number (\_\_\_\_) \_\_\_\_\_ Cell Number (\_\_\_\_) \_\_\_\_\_

**Emergency Contact Person:**

Parent / Guardian Name \_\_\_\_\_  
Address (if different from student) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Number (\_\_\_\_) \_\_\_\_\_ Work Number (\_\_\_\_) \_\_\_\_\_

**Alternate Contact Person:**

(please use someone near the contact)

Parent / Guardian Name \_\_\_\_\_  
Address (if different from student) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Number (\_\_\_\_) \_\_\_\_\_ Work Number (\_\_\_\_) \_\_\_\_\_

**Insurance**

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity.

Do you have insurance? Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_  
Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_  
In whose name is the insurance? \_\_\_\_\_

Family Doctor \_\_\_\_\_ City/Town \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_

If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him/her proper medical care during his/her time with the youth ministry activity.

**Health History:**

Pre-existing or present medical conditions: \_\_\_\_\_  
Name and dosage of any medications that must be taken: \_\_\_\_\_

Any Allergies? \_\_\_\_\_  
To Medications? \_\_\_\_\_

- \_\_\_\_ Hay Fever
- \_\_\_\_ Diabetes
- \_\_\_\_ Epilepsy/Nervous Disorders
- \_\_\_\_ Frequent Stomach Upset
- \_\_\_\_ any major illnesses during the past year?
- \_\_\_\_ Heart Condition
- \_\_\_\_ Insect Stings
- \_\_\_\_ Asthma
- \_\_\_\_ Physical Handicap

If any of the above are checked, please give details (include normal treatment of allergic reactions)

Date of last Tetanus Shot \_\_\_\_\_  
Any activity restrictions? \_\_\_\_\_ Yes \_\_\_\_\_ No  
What? \_\_\_\_\_

**Parent/Guardian Medical and Liability Release Statement:**

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during the activity dates shown on this form, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that my insurance coverage for my child will be used as a primary coverage in the event medical intervention is needed. Coverage by Longview Community Church through its accident policy will be used as a backup for what my family's insurance does not cover.

I understand all reasonable safety precautions will be taken at all times by Longview Community Church and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility risk. I agree not to hold Longview Community Church, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

**Parent / Guardian Signature**

\_\_\_\_\_ Date \_\_\_\_\_

**Signature of Student** (if over 18 years of age)

\_\_\_\_\_ Date \_\_\_\_\_

**EVENT :** \_\_\_\_\_

**Dates of Event:** \_\_\_\_\_

**Time of Event:** \_\_\_\_\_

**Cost of Event:** \_\_\_\_\_