



CHRIST EVANGELICAL LUTHERAN CHURCH

500 Park Street | West Salem, WI 54669-1130

Ph: 608-786-1250 Fx: 608-786-1105 Web: christlutheranwestsalem.com

YOUTH MEMBER PERMISSION SLIP & MEDICAL RELEASE FORM

I hereby grant permission for my child to participate in the activities of Christ Lutheran Church Youth Group of West Salem, WI. I understand that my child participates in these activities at their own risk and that Christ Lutheran Church and any of its adult supervisors or those allowing events to be held on their property are not liable for any injury personal or otherwise to my child or caused by my child. Should any problems arise concerning the behavior of my child that would require them to return home prior to the end of the activity, I will pay for his or her return or come pick my child up.

I authorize the treatment, by a qualified and licensed medical doctor, of the minor listed above in the event of any medical emergency which, in the opinion of the attending physician, is necessary and I/we cannot be reached after reasonable effort has been made to secure my personal consent.

I understand I am responsible for any medical expenses. _____ (initial)

Participant's Name _____ **Date of Birth** _____
Street Address _____
City _____ **State** _____ **ZIP** _____
Current Grade _____ **School** _____

Parent/Guardian Signature _____ **Date** _____
Home Phone _____ **Cell Phone** _____

Other Pertinent Contact Info _____

I understand that Christ Lutheran Church uses photographs and video images of events in our publicity materials such as the church website, newspapers, and newsletters. I hereby grant permission for images of my child to be taken and used for such purposes. _____ (initial)

EMERGENCY INFORMATION

Emergency Contact _____ **Relationship to Participant** _____
Daytime Phone _____ **Cell Phone** _____

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Daytime Phone _____ **Cell Phone** _____

MEDICAL INFORMATION

Medical Insurance Co _____ **Policy #** _____
Medical Facility _____ **Physician** _____
Street Address _____ **City** _____ **Phone** _____

Special Conditions (Allergies, medications, etc): _____

Any other information (special needs, concerns): _____

*This form expires one year from signed date.