Phone: 423-4769
Email: a.serflaten@sheridanlutheran.org

Activities Permission and Medical Authorization Form

I/We the parent(s) or legal guardian(s) of our son/daughter listed below hereby give my/our permission to participate in activities sponsored by Sheridan Lutheran Church. I/We understand that will be notified as soon as possible in the event of an emergency, but in the event I/we cannot be contacted immediately, I/we also hereby authorize and consent to emergency first aid, to medical examination and to x-ray, anesthetic, medical, dental, or surgical diagnosis, treatments and care rendered by or under the general or special supervision of licensed medical personnel.

This authorization is given in advance of specific diagnosis, treatment, or hospital care required, and is given to provide authority and power to render such diagnosis, treatment, and care which is deemed advisable in the best judgment of a medical doctor. It is understood that no diagnosis, treatment, or care will be withheld if the undersigned cannot be reached.

I/We understand that all I/we will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization. Should it be necessary for our/my child to return home due to medical reasons or otherwise, I/we will assume all transportation costs as well.

In the event of illness or injury, I/We waive and all claims now existing, known or un known, or arising hereafter, and specially agree that Sheridan Lutheran, Lincoln, Nebraska and any related employees or entity, their agents, and any volunteers connected with this activity are fully released from any and all liability and damages except for those arising from the negligent acts or omission of the church, its agents and employees, or activities leaders.

Name of Youth: ________________________________ Age:_____ Date of Birth: __________
Address: ______________________________
____

Parent/Guardian Name (printed)____

Home phone ( ) ______________________ Cell Phone/other ( ) ________________________
School: ________________________ School Current Grade: ______________________
Parent(s) business phone(s): ____
Alternate person to contact: ______________________________ Phone ( ) ________________

(include a copy of both sides of your current insurance card to be kept on record)

Family Health Insurance Provider____
Policy Number __________________________ Verification phone # ( )__________________
Family Doctor ( )______________________________ Phone ( ) ____________________
Our/My child takes the following prescribed medications:________________________________
and I/We hereby ____give/____deny permission for him/her to administer the medications to himself/herself.

My/Our child is allergic to: ____
____
Other special instructions: ____
____

Mother/Guardian Signature:______________________________ Date: ____________

Father/Guardian Signature:______________________________ Date:____________

Youth Signature: ______________________________ Date:____________