

REVOLUTION YOUTH MINISTRIES PERMISSION SLIP & MEDICAL RELEASE

NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ ZIP _____

PARENT(S) OR LEGAL GUARDIAN NAME _____

CONTACT #S HOME _____ CELL _____ CELL#2 _____

DOCTOR'S NAME AND PHONE _____

MEDICAL INSURANCE _____

ID# _____ Company _____ Plan _____

ANY KNOWN ALLERGIES (FOOD, MEDICAL) OR MEDICAL CONDITIONS _____

MEDICAL RELEASE (must be signed by parent or guardian)

I hereby give my consent to any emergency medical or surgical care which may be deemed necessary to my daughter/son named above while participating in activities with TRINITY FAMILY LIFE CENTER. I understand a reasonable attempt will be made to contact me before use of this consent is made.

(Date Signed)

(Parent/Guardian Signature)

(Date Signed)

(Parent/Guardian Signature)