

# Seminole Presbyterian YOUTH

## PERMISSION/MEDICAL RELEASE FORM

2011-12

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

School \_\_\_\_\_ Current Grade \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Guest?  N  Y Invited by \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

*I give permission for my child to join Seminole Presbyterian Church on their activities and/or programs from September 1, 2011-August 31, 2012. I also give permission for my child to be transported in a vehicle by a staff member or volunteer of Seminole Presbyterian. I understand at certain events there may be opportunity to swim in a pool or lake and though a responsible adult will be supervising, a certified lifeguard may or may not be present.*

**Knowing the above I give my child permission to swim (check one)  YES  NO**

*I hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Seminole Presbyterian Church and its officers, staff, volunteers, and/or anyone else involved with said organization from any and all claims, actions, or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my child's (or my) use of any and all equipment, my child's (or my) participation in any and all activities and/or programs, and/or my child's (or my) involvement in any and all modes of transportation. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by officers, staff, volunteers, or any person involved with Seminole Presbyterian Church.*

*In the event of an emergency, I hereby authorize an adult leader of the activity, as an agent for me, to consent to any medical or dental examination and subsequent treatment as advised by a licensed medical practitioner. I expect to be contacted as soon as possible about any such medical problems.*

### Medical Information

Allergies/Medical Conditions: \_\_\_\_\_

Current Medications \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Insured's Name \_\_\_\_\_

Please include a copy of your insurance card.

Signature of parent/legal guardian **X** \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Must Have Signature Notarized

(print name) \_\_\_\_\_

In witness Whereof, we have set our hand and seal this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

State of \_\_\_\_\_

County \_\_\_\_\_

\_\_\_\_\_  
Notary

