

### Sports and Youth Activity Permission Form

Activity: \_\_\_\_\_

Date of Activity: \_\_\_\_\_

Minor's Name: \_\_\_\_\_

Minor's Address: \_\_\_\_\_

Minor's Phone Number: \_\_\_\_\_

I, \_\_\_\_\_, the parent or legal guardian of the above-named minor, hereby give my permission for his/her participation in the youth activities named above. I agree to direct my child to cooperate and conform to directions and instructions of personnel responsible for the activities.

I agree that in the event my child is injured as a result of his/her participation in the above-named activities, including transportation to and from these activities, whether or not caused by the negligence (active or passive) of the activity of the church program, or any of its agents or employees; recourse for the payment of any hospital, medical, dental, or related costs and expenses will be paid either by me or my spouse, accident, hospital or medical insurance, or any available benefit plan of mine or my spouse.

I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physical, surgeon, and dentist licensed under the Medical Practice Act and Dental Practice Act. As parent or legal guardian, I am responsible for the health care decisions of my child and am authorized to consent to services to be rendered, and no other consent is required by law.

I hereby give permission to the physician selected by the activities supervisory personnel then present to render medical treatment deemed necessary and appropriate by the physician or dentist.

\_\_\_\_\_  
Parent or Legal Guardian Signature Date

\_\_\_\_\_  
Print Name of Parent or Legal Guardian Relationship

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Contact Person (other than parent): \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Name & Phone of Primary Doctor: \_\_\_\_\_

Health Plan & Policy Number: \_\_\_\_\_

Allergies or Medicine Allergy: \_\_\_\_\_