



Permission Slip and Medical Release Form
Activity: Parent's Night Out at Woodland Hills Church
Date: February 14, 2012

Child's Name: _____ Date of birth: _____ Age: ____ Sex: ____
Child's Name: _____ Date of birth: _____ Age: ____ Sex: ____
Child's Name: _____ Date of birth: _____ Age: ____ Sex: ____
Child's Name: _____ Date of birth: _____ Age: ____ Sex: ____
Address: _____
Home Phone: _____ Cell Phone: _____
Other _____

I, _____ (*printed name of parent/guardian*) being the parent or legal guardian of _____ (*printed name of minor(s)*) have been informed of the above activity sponsored by Woodland Hills Church and hereby give my consent for my minor child/children to participate in this activity. I understand that all reasonable safety precautions will be taken by the leaders/volunteers of this activity, and that the possibility of an unforeseen hazard does exist. I further agree not to hold Woodland Hills Church, its leaders and volunteer staff liable for damages, losses, diseases, or injuries incurred by the minor(s) listed on this form.

CONSENT TO TREAT A MINOR

Being the parent or legal guardian of

_____, (*print name of minor(s)*) I _____ (*print name of parent/guardian*) do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child(s). Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leaders to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child(s). I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian I am responsible for the health care decisions for my minor child(s) and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child.

Primary Physician Name: _____
Phone # _____
Health Insurance Name: _____
Policy number: _____

Parent/Guardian Signature: _____ **Date:** _____