2024-2025 Springfield Oaks Church Youth Ministry PERMISSION SLIP

Youth #1(first and last name) :_____ Grade: _____

Birthday: _____ Allergies: _____

Youth Cell # _____

Youth #2 (first & last name): _____ Grade: _____

Birthday: _____ Allergies: _____

Youth Cell # _____

Parent's Name (first and last): _____

Address:_____

Cell Phone:_____

Best Email:_____

Consent to treat agreement: We, the parents/guardians of the child(ren) named herein, do assume all risks and hazards incidental to the conduct of the Springfield Oaks Church Youth Ministry activities. We hereby waive all claims against Springfield Oaks Church, the organizers, sponsors, and/or supervisors appointed by them. I (We) understand that, in the event medical treatment &/or transportation is required, every effort will be made to contact me (us). However, if I (we) cannot be reached, I (we) give permission to the staff or sponsor of Springfield Oaks Church to secure services of a licensed physician &/or licensed paramedics to provide necessary care for my child/children's well-being.
___ I accept the Consent to Treat Agreement

Alternate Emergency Contact Name (first and last) _____

Alternate Emergency Phone Number _____

Insurance Company:_____ Policy # _____

Address Ins Co:_____ Phone # _____

Insured Employer: _____

____**Photo Release:** Photos of my child(ren) may be used for purposes to promote the Youth Ministry of Springfield Oaks Church

____**Transportation Permission Slip & Release:** I give my child(ren) full consent to attend Springfield Oaks Church youth activities during the year of 2024-2025, including transportation to and from events by church bus, van, or private car when necessary. It is my understanding that the staff and volunteers of Springfield Oaks Church will take all of the necessary precautions to ensure the safety of my children. I do hereby release the above stated organization from any legal or financial obligation due to the injury of my minor child(ren).

I understand that my child(ren) will be expected to behave in a way that would properly represent themselves and Springfield Oaks Church.

Parent/Guardian Signature:_____ Date: _____

Any other information you feel that we should know:(medications, illness, etc...) _____

Springfield Oaks Church
Student Information and Medical Release Form

Student Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ___ Zip _____
Home Phone: _____ Age: _____

Emergency Information:
Father's Name: _____ Cell Phone: _____ Work Phone: _____
Mother's Name: _____ Cell Phone: _____ Work Phone: _____
In an emergency, when parents cannot be reached, please contact:
Name: _____ Cell Phone: _____
Name: _____ Cell Phone: _____

Allergies: _____

Other Medical Conditions: _____

Family Physician: _____ Phone: _____
Medical and/or Hospital Insurance Company: _____
Phone: _____
Policy Holder: _____ Policy #: _____ Group #: _____

Please copy both sides of your medical insurance card and attach to this form:

Parent's approval and medical release
In the event of an accident, and I am unable to be reached, I grant permission to an adult staff member to seek and/or obtain medical assistance that may be necessary. I hereby give my consent to have a trainer and/or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of each assistance and/or treatment.

_____ _____
Signature of Parent/Guardian Date

Springfield Oaks Church
Over the Counter & Prescription Medication Permission Form

Youth's First Name:_____ Last Name: _____
Allergies: _____

Parent/guardian should list any over the counter medication that may be given to the youth in case of illness. In addition, list any/all medication routinely taken by the youth including prescription and over the counter medications.

Check Yes or No to indicate if you allow your youth to receive the following medications while participating in the Youth Ski Trip to Teen Valley Ranch.

1. Administration of Acetaminophen (Tylenol) or Ibuprofen (Motrin or Advil) at an age appropriate or weight appropriate dose for discomfort, pain, or fever
____Yes ____ No *** Parent/Guardian will be contacted if student's fever is 100 F or higher.

2. Diphenhydramine (Benadryl) for symptoms of allergic reactions, insect stings, or rashes at an appropriate dose
_____Yes _____No

3. Cough Drops for coughing _____Yes ____ No

4. Itch and rash relief cream/ointment for minor skin irritations _____Yes ____No

5. Triple antibiotic ointment for minor skin abrasions/wounds _____Yes ____No

Please list any prescription or over the counter medications your youth is currently taking. This information is necessary if your youth is to be treated by a medical professional. Examples: Claritin, vitamins, etc.
I am the parent/guardian of _____ and give permission for the medications listed to be administered as directed. By signing below, I am agreeing the information is currently correct.

Medication: _____Condition being treated for:_____
Medication: _____Condition being treated for:_____
Medication: _____Condition being treated for:_____
Medication: _____Condition being treated for:_____

Parent/Guardian Signature: _____ Date: _____