

**Cumberland United Methodist Church
EVENT PERMISSION SLIP & HEALTH FORM**

Date _____

_____ has my permission to attend **Pilgrimage** at **The Crown Coliseum** from **11-13 November, 2011**

I hereby release and indemnify Cumberland United Methodist Church (CUMC), staff, youth leader and adult youth advisors/chaperones from any and all liability arising from claims of any kind or nature whatsoever from my child/youth's participation in this event. I also grant permission for the CUMC, staff, youth leader and adult volunteers/chaperones for the administration of first aid to my child/youth by those people in charge of this event and those transporting to and from the program as their judgment deems advisable, and to make the necessary referrals to qualified physicians for treatment of illness or accident of a more serious nature. I understand that I will be promptly notified in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In the case of a medical emergency, I understand that every effort will be made to contact the parents/guardian of the participant. In the event I cannot be reached, I hereby give permission to the physician/hospital selected by the adult staff or volunteers of CUMC to hospitalize, secure proper treatment for and order injections, anesthesia and/or surgery, if deemed necessary for my child/youth.

X _____ Relationship _____
(Parent or Guardian signature)

Age _____ Date of birth ____/____/____. Current grade in school _____.

(Street address) _____

(City) _____ (State) _____ (Zip) _____

(Area code/phone number) _____ (Cell Phone) _____

Other Parent/Guardian _____ Relationship _____

(Street address) _____

(City) _____ (State) _____ (Zip) _____

(Area Code/phone number) _____ (Cell Phone) _____

Do you have health insurance? _____ Policy Name _____

Policy number _____ Policy Holder _____

You may provide a copy of the health insurance ID at time of departure, if you prefer.

Emergency Contact Person (other than parent or guardian)

_____ Relationship _____

(Area Code/Phone number) _____

1. Does he/she had any physical disability? Yes No What? _____

2. Does he/she have any allergies? Yes No What? _____

3. Does he/she take medicine? Yes No What? _____

4. Has he/she had a tetanus shot? Yes No When? _____

5. Is your child subject to (circle appropriate choices)

Headache	Asthma	Constipation	Nose Bleeds	Bed wetting
Hysteria	Spasms	Hay fever	Nightmares	Indigestion
Fainting	Sinus infection	Talking in sleep	Sleep walking	

6. Is there anything else you think we should know? Please state on back of page.