Lord of Life Youth Activities Permission Slip

Lord of Life Event:_____

Full Name of Student: _____

Gender (circle) Male/Female D.O.B - _____

Address: _____

Emergency Contacts

Contact 1: Name: _____ Number: _____
Contact 2: Name: _____ Number: _____

Family Doctor's Name: _____ Number: _____

Are there any disabilities or special needs we need to know about?

Are you on any current medication e.g antibiotics, ADHD medicine, etc?

Do you have any ongoing medical conditions such as asthma or allergies that require medication?

Any special dietary needs?

Any Medication should be handed into the main leader and it will be supplied when needed. If the medication needs to be carried by your son/daughter this must be agreed with the organizers. All information will be kept confidential, we cannot accept responsibility for any information not declared.

I, the Parent/Guardian hereby give my permission for _____ to participate in this activity.

I, the Parent/Guardian declare all of the information provided is correct.

Print Name: _____ Signature: _____

Health Insurance Carrier:_____

Policy # _____ Group #_____