



# St. Mark's Lutheran Church

## Events Form

### Permission Slip and Photo Release

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Today's Date \_\_\_\_\_

Participant's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender \_\_\_\_\_

Home Address \_\_\_\_\_ Age \_\_\_\_\_ Grade (as of date on form) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Does participant attend church? \_\_\_\_\_  
If so, where? \_\_\_\_\_

Please print clearly in ink and use a separate form for each participant. The information on this form, but is gathered to assist us in identifying appropriate care of participants. This form must be filled out by parents/guardians of minors. An update is required annually.

Parent or Guardian Name(s) \_\_\_\_\_

Phone numbers where you can be reached during the day (please circle best number to call)

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Cell # \_\_\_\_\_

Home Address (if different than participant address)

\_\_\_\_\_ Email address \_\_\_\_\_

Emergency Contact (other than above) \_\_\_\_\_

Daytime Phone \_\_\_\_\_

Relationship to participant \_\_\_\_\_ Is participant covered by medical/hospital insurance?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate carrier plan or name \_\_\_\_\_

Group Number \_\_\_\_\_

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#### Parent/Guardian Photo Authorization:

I give St. Mark's Lutheran church and any individual acting as its agent permission to use photography/video of myself/my child taken on St.Marks' outings/events.

Signature of parent/guardian \_\_\_\_\_

Date \_\_\_\_\_

St. Mark's Lutheran Church Events Form  
Medical Information/Release

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Allergies - Please list all known allergies

Medication Allergies

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Describe reaction and management of reaction

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Food Allergies

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Describe reaction and management of reaction

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Other Allergies

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Describe reaction and management of reaction

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Current Medications \_\_\_\_\_

Reason (s) for taking \_\_\_\_\_

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Medical Conditions: Does the participant have any medical conditions of which the St. Mark's event leaders should be aware? Please use this space to describe.

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Restrictions The following restrictions apply to this individual. Please explain any activity restrictions (i.e. what cannot be done, what adaptations or limitations are necessary)

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Additional Information

Please use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the St. Mark's leaders/chaperones should be aware. The better informed the event leaders can be, the better they will be able to provide for the needs of your child.

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Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family Dentist/Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian Authorization: This health history is correct and complete as far as I know. The person herein described has permission to engage in all St. Mark's activities except as noted. I hereby give permission to the St. Mark's leaders/chaperones to provide routine health care and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for medical treatment, referral, billing or insurance purposes. I give permission to the St. Mark's leaders/chaperones to arrange necessary related transportation for me/my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the St. Mark's leaders/chaperones to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian or adult participant \_\_\_\_\_

Date \_\_\_\_\_