

**2010-2011 "LifeTeen" VISITOR Permission Form and Medical Release**

*St. Lawrence Catholic Church*

PLEASE: *Complete* both sides of form. *Sign* form at bottom of front and back pages.

**FAMILY INFORMATION**

Street Address: \_\_\_\_\_

City: \_\_\_\_\_, **GA** Zip: \_\_\_\_\_

Subdivision: \_\_\_\_\_

Home phone number: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

**Parent/guardian**

**Spouse/significant other**

Last name: \_\_\_\_\_

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

First name: \_\_\_\_\_

Title (check one):  Mr.  Mrs.  Ms.  Dr.

Title (check one):  Mr.  Mrs.  Ms.  Dr.

Relationship to student: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Work phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Place of Business: \_\_\_\_\_

Place of Business: \_\_\_\_\_

E-mail address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

**STUDENT INFORMATION**

1. Name _____ Date of Birth _____ Age _____ <i>Grade as of Sept. 1, 2010</i> _____ School _____ Sex: M F Any special conditions of which we need to be aware _____ _____
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**PERMISSION**

The student listed above has been invited by \_\_\_\_\_ a member of  
*(St. Lawrence student's name)*  
St. Lawrence "LifeTeen" program. I understand my youth is subject to all St. Lawrence Youth Ministry policies  
and has my permission to attend any and all LifeTeen activities on \_\_\_\_\_  
*(date)*

I HAVE READ, UNDERSTAND AND CONSENT TO THE ABOVE \_\_\_\_\_  
Parent/guardian signature Date

(Continued on reverse side)

**MEDICAL RELEASE**

**Name of Student:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Student's Social Security No.: \_\_\_\_\_ (Required for treatment in most Hospitals) (optional)

Emergency contact \_\_\_\_\_ Phone # \_\_\_\_\_

Relation to student \_\_\_\_\_

Medical / Hospital Insurance Carrier \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Relation to participant \_\_\_\_\_

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

**Medications:** My child is taking the following medication(s):

Description \_\_\_\_\_ Dosage \_\_\_\_\_

Description \_\_\_\_\_ Dosage \_\_\_\_\_

(EITHER A PHYSICIAN'S PRESCRIPTION OR PARENT NOTE MUST ACCOMPANY ALL MEDICATIONS. PRESCRIPTION / NOTE SHOULD BE ATTACHED TO THIS FORM.)

**Drug allergies:** \_\_\_\_\_

**Other allergies / reactions** (food, plants, insects, etc.) \_\_\_\_\_

**List any other health problems / limitations that we need to be aware of:** \_\_\_\_\_

- **Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical attention. I wish to be advised prior to any further treatment by the doctor**
- **If you are unable to reach parent/guardian or the emergency contact person, I hereby grant permission for the doctor and hospital to exercise professional judgment in treating participant.**
- **I hereby grant permission for non-prescription medications to be given, if deemed appropriate.**

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_