2010-2011 "The EDGE" 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

Last name: ______________________

First name: ______________________

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

Relationship to student: ______________

Cell phone: ______________________

Work Phone: ______________________

Place of Business: ______________________

E-mail address: ______________________

Spouse/significant other

Last name: ______________________

First name: ______________________

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

Relationship to student: ______________

Cell phone: ______________________

Work Phone: ______________________

Place of Business: ______________________

E-mail address: ______________________

STUDENT INFORMATION

1. Name ______________________ Date of Birth ______________ Age _____

Grade as of Sept. 1, 2010 ________ School ______________________ Sex: M F

Any special conditions of which we need to be aware ______________________

____

CONSENT

The student listed above has been invited by ______________________ a member of
(St. Lawrence student's name)

St. Lawrence "The Edge" program. I understand my youth is subject to all St. Lawrence Youth Ministry policies and has my permission to attend any and all The Edge 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 _________________