

# Grover Park Baptist Church

## Mission Trip/Travel Permission and Medical Consent

As parent or legal guardian, I hereby give permission for my student to participate in the following activity organized by Grover Park Baptist Church:

Name of Activity: SLAM – Students Living a Mission Date of Activity: March 5 – 7, 2010

Location: \_\_\_\_\_

Student's full name \_\_\_\_\_

Sex \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian Name \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_ Phone \_\_\_\_\_

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

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

Name \_\_\_\_\_ Phone \_\_\_\_\_

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

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

Does this student have any of the following allergies:

Penicillin \_\_\_\_\_ Other \_\_\_\_\_

Other drugs \_\_\_\_\_

Insect Stings \_\_\_\_\_

Ivy Poisoning, etc. \_\_\_\_\_

Hay Fever \_\_\_\_\_

Does this student have any medical or health problems, and has this child had any chronic or recurring illness or illnesses, which would have an effect on the student's participation in this activity? ( ) YES ( ) NO

If yes, describe the problems or illnesses \_\_\_\_\_

State the name, address, medical specialty, and phone numbers of this student's family physician and of any other physicians who should be consulted in the event of emergency or medical problems involving this student:

State the name, address, and phone number of the student's dentist (and orthodontist if applicable):

Is there medical or hospitalization insurance which provides benefits for this student: ( ) YES ( ) NO

If so, please indicate:

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Policy # of Insurance Policy \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Phone # of Insurance Co. (\_\_\_\_\_) \_\_\_\_\_

Indicate the date of this student's last tetanus shot \_\_\_\_\_

Are there any activities, such as strenuous activities, to be restricted for this student? \_\_\_\_\_ If so, describe:

\_\_\_\_\_  
\_\_\_\_\_

Is this student on any medications? \_\_\_\_\_ If so, please state the medication: \_\_\_\_\_

\_\_\_\_\_  
If so, will this student be bringing to the activity the medications that he/she should be taking? \_\_\_\_\_

Describe any dietary restrictions that this student is required to observe \_\_\_\_\_

\_\_\_\_\_  
Other comments or suggestions from the parent or guardian concerning this student \_\_\_\_\_

I understand that **Grover Park Baptist Church** carries medical and hospitalization insurance coverage which, consistent with the exclusions, limitations, and terms thereof, may provide benefits over and above any personal medical and hospitalization coverages available to my family. I understand that any personal medical and hospitalization insurance available to my family will provide primary coverage and the church's medical and hospitalization coverage (subject to the exclusions, limitations, and provisions in the church's policy) may provide secondary or excess coverage. I agree to apply first for benefits from the personal hospitalization and medical coverages available to my family, if any, before applying for benefits that may be available from the church's medical and hospitalization coverage.

I further understand that, in the event my student requires medical or dental treatment while engaged in the activity, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the church's sponsor or any adult counselor acting on behalf of the church with respect to the activity, as agent for me, to consent to any X-ray examination, injections, anesthesia, medical, dental, or surgical diagnosis and treatment, and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my student's medical allergies, medications being taken, medical problems, and other pertinent information. My child has permission to participate in all prescribed activities except as noted by me.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian)

Witness \_\_\_\_\_ Date \_\_\_\_\_