

Church of Christ in Livonia 15431 Merriman Rd. Livonia, MI 48154

**PERMISSION FORM**

Duration September 1, 2008 – August 31, 2009

**PART 1: For the Student**

*I \_\_\_\_\_ (Student), desire to participate in the activities of the Church of Christ in Livonia Youth Ministry, and promise to follow the instructions of the Youth Ministry Staff and Volunteers and to respect the rights of others. I promise not to bring or use alcohol, tobacco, weapons, illegal drugs, or fireworks. I agree, if I violate this promise, my Parent(s)/Guardian(s) may be notified and I may be sent home at my expense, before the activity is over. The duration of this agreement is one year, and lasts for the time slot designated above.*

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ Birth date \_\_\_\_\_

**PART 2: For the Parent/Guardian**

*I/We the undersigned, hereby grant \_\_\_\_\_ (son/daughter) my/our permission to attend and participate in the activities off-campus, and all activities included in the Youth Ministry of the Church of Christ in Livonia. We hereby give permission for the above-named minor to ride in any vehicle designated by the Youth Ministry Staff in whose care the minor has been entrusted while attending and participating in activities sponsored by the Church of Christ in Livonia.*

**LIABILITY WAIVER**

*I/We further permanently release and hold harmless the above named organizations, the individual Volunteer Staff Members and all Staff Members and Leaders of the Church of Christ in Livonia from any civil liability for loss, injury, or damage to my son/daughter or property which may result from his/her participation. The duration of this agreement is one year and lasts for the time slot designated above.*

**LIMITED PURPOSE POWER OF ATTORNEY**

*Consent to Treatment of a Minor*

- A. The undersigned appoint and delegate the Youth Ministry Staff the power to consent on our behalf to all emergency treatment and/or medical/dental care (except elective) of \_\_\_\_\_ (son/daughter) determined to be necessary or desirable by the youth's attending physician/dentist at his/her hospital
- B. The Power of Attorney shall continue for the duration of the trip or until revoked in writing by the undersigned. Physicians, medical staff or dentist may assume and rely that this authorization is in effect unless notified.
- C. The undersigned certify that they have read and understood this Power of Attorney.
- D. In the event of medical/dental treatment, parents/guardians are completely responsible for any treatment cost incurred.

## HEALTHCARE INFORMATION

1. Student Name \_\_\_\_\_
2. Insurance Company \_\_\_\_\_
3. Policy Holder Name \_\_\_\_\_
4. Policy Number \_\_\_\_\_ Group # \_\_\_\_\_
5. Insurance Company Address \_\_\_\_\_  
\_\_\_\_\_
6. Insurance Company Phone Number \_\_\_\_\_
7. Prescription Insurance (if different from above): Company \_\_\_\_\_  
Policy Holder \_\_\_\_\_  
Policy Number \_\_\_\_\_
8. Allergies \_\_\_\_\_
9. Medications now being taken \_\_\_\_\_  
\_\_\_\_\_
10. Conditions/problems \_\_\_\_\_
11. Additional information \_\_\_\_\_

### UNDERSIGNED SIGNATURE OF PARENT OF GUARDIAN

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to minor: \_\_\_\_\_

Father Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work # \_\_\_\_\_

Mother Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work # \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_  
\_\_\_\_\_

2nd Emergency contact: \_\_\_\_\_

Relationship to minor: \_\_\_\_\_ Phone: \_\_\_\_\_

In case of the need for medical or dental attention, the Youth Ministry Staff will contact you as quickly as possible.

Notary seal and signature:

Date: