Permission Slip and Medical Consent Authorization Form

Las Flores Church * 1400 Las Flores Drive * Carlsbad, CA 92008

(We) I the undersigned parent(s) or legal guardian(s) of: NAME: _____

(Please print minor's name.)

a minor, do hereby authorize representatives of the LAS FLORES CHURCH OF THE NAZARENE, Carlsbad, California, as agent(s) for the undersigned, to consent to any emergency diagnostic procedure and any medical or surgical treatment required and deemed advisable by any duly licensed physician and surgeon, or under this or her general or special supervision. It is understood that this authorization is being granted for emergency medical and/or surgical care only, and that all usual means shall be used to notify the undersigned prior to commencement of any major procedure. It is understood that such specification shall not prohibit the institution of such emergency care as is necessary to preserve the life of the above minor.

We (I) further do attest approval of this authorization and do certify as to its correctness, expressly waiving any and all claims against the LAS FLORES CHURCH OF THE NAZARENE, Carlsbad, California, or any of its Boards or representatives because of the injury or other damage that may be incurred to the above minor or said minor's property in connection with any incident during the trip.

Further, I hereby grant permission for the above name child to participate in _____ which will take place on _____.

I understand that this trip will be taken by ( ) auto ( ) van ( ) boat ( ) bus (check one.) I further understand that an authorized adult will be in charge at all times and will take necessary measures to the best of his or her ability for the protection of health and safety of the group.

X _____ _____/_____/_____

Signature of Parent or Guardian — Date

_____ ( ) _____ - _____

Address: City, State, Zip — Home Phone

EMAIL:_____ ( ) _____ - _____

Cell Phone

In case of emergency notify:

_____ ( ) _____ - _____

Please Print Name — Cell Phone

_____

Address

Special Medical Conditions of Minor, such as DIABETES, ALLERGIES, etc.

_____

Medication Currently Using:

_____

Insurance Info:

Insurance Company Name _____ Policy #_____

Doctor's Name _____ ( ) _____ - _____
Please Print Name Phone

MAKE CHECKS PAYABLE TO LAS FLORES CHURCH or

PAY ONLINE @ rootedyouth.com
If paying online, please add 3% to your total to cover the transaction fees.