PERMISSION FORM

My student ____ has my permission to go

to ____ with the Canton Baptist Temple

____________________________ Department on ______________________.

I understand every precaution will be taken for the care and safety of my student and all those attending this event. Nevertheless, I do hereby agree not to hold Canton Baptist Temple, the Board, or any personnel liable for an accident or other mishap which might occur while traveling to and from or during the stay at the above named event.

______ I have already filled out an emergency medical authorization form for the church and all of the information is current.

______ I will fill out an emergency medical authorization form and return it with this permission slip.

_________________________ (Date)

____ (Parent / Guardian Signature)

_________________________ (Date)

____ (Witness)

EMERGENCY MEDICAL AUTHORIZATION

THE FOLLOWING INFORMATION IS CURRENT:

❑ ____/____/08 ❑ ____/____/09 ❑ ____/____/10

Child / Teenager Name ____________________

Address ____________________

City____________________ State__________ Zip__________

Phone Number____________________ Date of birth____________________

Social Security # ____________________ Date of Last Tetanus Immunization __________

I authorize any representative from Canton Baptist Temple to have the power to grant consent to any emergency medical treatment / care, including required tests, to the above named child / teenager if I or the other parent cannot be reached.

Father____________________ Home Phone__________

Address____________________ Work Phone__________

Mother____________________ Home Phone __________

Address____________________ Work Phone__________

Relative ____________________ Home Phone__________

Address____________________ Work Phone__________

In the event reasonable attempts to contact the above persons have been unsuccessful, I hereby give my consent for the following local medical care providers and local hospital to be called or child / teenager taken there when within reasonable traveling distance. When not within reasonable traveling distance, or in the case of long distance trips or out of state trips, I give my permission for my child / teenager to be treated at the nearest medical facility available.

Doctor____________________ Phone__________

Dentist____________________ Phone__________

Medical Specialist____________________ Phone__________

Hospital____________________ Phone__________

This authorization does not cover major surgery unless the medical opinion of a second licensed physician or dentist concurring in the necessity for such surgery is obtained BEFORE THE SURGERY IS PERFORMED.

Facts concerning my child's / teenager's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted. ____________________

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____________________ (Date)

____________________ (Signature of Parent)

My Insurance Carrier is ____________________Policy #__________

(Original travels with Superintendent; copy remains on file in the Church Office)