

# First Assembly of God

2317 Madison Ave. ~ PO Box 1679 ~ Granite City, Illinois 62040 ~ 618-451-1200

## PERMISSION SLIP AND LIABILITY WAIVER FORM

My child, \_\_\_\_\_ is in good health, and has my permission to ride the church van, bus or personal vehicle and to attend church sponsored events scheduled from January 2007 thru December 31, 2007. I know of no physical reason that would restrict my child from participating in church related or recreational activities unless noted below. In an emergency, a church leader has my permission to authorize emergency, life saving medical treatment. Further, I hereby voluntarily waive any claim against First Assembly of God, the Illinois District of Assemblies of God and it's sponsoring institutions and all church leaders, members or attendees for any and all causes which may arise in connection with activities, services or events. This permission slip and liability waiver is perpetual and may only be revoked or revised in writing by the child's parent or legal guardian.

**PLEASE FILL IN ALL BLANKS AND PRINT CLEARLY.**

Full Name of Child: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number \_\_\_\_\_

Child's Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Parent or Legal Guardian: \_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Pager: (\_\_\_\_\_) \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Insurance Information: \_\_\_\_\_

(Over Please)

**HEALTH HISTORY**

<b><u>HAS HE/SHE HAD:</u></b>	<b><u>YES</u></b>	<b><u>NO</u></b>	<b><u>IS HE/SHE SUBJECT TO:</u></b>	<b><u>YES</u></b>	<b><u>NO</u></b>
<b>Appendicitis Attack before?</b>	_____	_____	<b>Sinus Problems</b>	_____	_____
<b>Asthma or Hay Fever</b>	_____	_____	<b>Fainting Spells</b>	_____	_____
<b>Hernia (rupture)</b>	_____	_____	<b>Ear Problems</b>	_____	_____
<b>Rheumatic Fever</b>	_____	_____	<b>Convulsions</b>	_____	_____
<b>Diabetes</b>	_____	_____	<b>Poison Ivy, Oak or Sumac</b>	_____	_____
<b>Does he/she take Insulin</b>	_____	_____	<b>Reaction to Penicillin</b>	_____	_____
<b>Poliomyelitis</b>	_____	_____	<b>Nervousness or Easily upset</b>	_____	_____
<b>Severe Allergies</b>	_____	_____	<b>Allergy to Aspirin</b>	_____	_____
<b>Scarlet Fever</b>	_____	_____	<b>Date of Last Tetanus Shot</b>	_____	_____
<b>Significant Disease, Injury Or Operation</b>	_____	_____	<b>Is he/she activity restricted due to medical reason?</b>	_____	_____
<b>Is he/she under medical care Requiring medication?</b>	_____	_____			



**If you marked “Yes” to any of the above please explain. If there are known allergies and/or reactions To medications, please explain. Or if there are any other special medical problems not listed above that should be noted about the above individual please explain below.**

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