

Phone: 402-423-4769

Email: info@sheridanlutheran.org

## Activities Permission and Medical Authorization Form

I/We the parent(s) or legal guardian(s) of our son/daughter listed below hereby give my/our permission to participate in activities sponsored by Sheridan Lutheran Church. I/We understand that will be notified as soon as possible in the event of an emergency, but in the event I/we cannot be contacted immediately, I/we also hereby authorize and consent to emergency first aid, to medical examination and to x-ray, anesthetic, medical, dental, or surgical diagnosis, treatments and care rendered by or under the general or special supervision of licensed medical personnel.

This authorization is given in advance of specific diagnosis, treatment, or hospital care required, and is given to provide authority and power to render such diagnosis, treatment, and care which is deemed advisable in the best judgment of a medical doctor. It is understood that no diagnosis, treatment, or care will be withheld if the undersigned cannot be reached.

I/We understand that all I/we will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization. Should it be necessary for our/my child to return home due to medical reasons or otherwise, I/we will assume all transportation costs as well.

In the event of illness or injury, I/We waive and all claims now existing, known or unknown, or arising hereafter, and specially agree that Sheridan Lutheran, Lincoln, Nebraska and any related employees or entity, their agents, and any volunteers connected with this activity are fully released from any and all liability and damages except for those arising from the negligent acts or omission of the church, its agents and employees, or activities leaders.

**Name of Student:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Student Cell:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Graduating Year:** \_\_\_\_\_

**Parent/Guardian Name (printed)** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
\_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home phone ( )** \_\_\_\_\_ **Parent Cell Phone/other ( )** \_\_\_\_\_

**Parent(s) business phone(s):** \_\_\_\_\_

**Alternate person to contact:** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_

**Alternate person to contact:** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_

(include a copy of both sides of your current insurance card to be kept on record)

**Family Health Insurance Provider/Policy Number:** \_\_\_\_\_

**Verification phone # ( )** \_\_\_\_\_ **Date of Last Tetanus Shot:** \_\_\_\_\_

**Family Doctor ( )** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_

**Our/My child takes the following prescribed medications:** \_\_\_\_\_

and I/We hereby \_\_\_give/\_\_\_deny permission for him/her to administer the medications to himself/herself.

**My/Our child is allergic to:** \_\_\_\_\_

**Other special instructions:** \_\_\_\_\_

**Mother/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Father/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Youth Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_