

## Off Campus Event - Parent Permission Form (Middle School Ministry)

Name of Event: \_\_\_\_\_

Destination: \_\_\_\_\_

Designated Supervisors of Activity: Middle School Ministry at St. Patrick St. Anthony

Date & Time of Departure: \_\_\_\_\_

Date & Anticipated Time of Return: \_\_\_\_\_

Method of Transportation: \_\_\_\_\_

Student Cost: \_\_\_\_\_

As parent or legal guardian, you remain fully responsible for any legal responsibility which may result from any personal actions taken by the named student.

I hereby consent to participation by my child \_\_\_\_\_, in the event described above. I understand that this event will take place away from the church grounds and that my child will be under the supervision of the designated church employee on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

\_\_\_\_\_  
(Print Parent/ Guardian Name)

\_\_\_\_\_  
(Emergency Contact Number)

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Email Address)

**A 2022-2023 medical treatment release form must be submitted with this permission form, unless already submitted since July 2020.**

**Medical Treatment Release Form** (good for entire year)

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency, which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Reason for which release is intended: All 2022-2023 High School Ministry Events

Address of Minor: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Emergency Phone: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**List any allergies, medication, contacts, or other pertinent comments:**

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**Health Insurance Data:**

Company: \_\_\_\_\_ Policy: \_\_\_\_\_

Group: \_\_\_\_\_ Contract: \_\_\_\_\_

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence

**THIS FORM MUST BE NOTARIZED IF EVENT TAKES PLACE OUT OF STATE**

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

Signed: \_\_\_\_\_

(Parent or Guardian)

~~~~~State  
of: \_\_\_\_\_ Subscribed and sworn to, before me this

County of: \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
(Notary Public for the State of Michigan)

My Commission Expires \_\_\_\_\_

County of \_\_\_\_\_