

## Permission and Medical Consent

As parent or Legal guardian, I hereby give permission for my child to participate in the First United Methodist Church of Downers Grove, IL Youth Group's **Ski Trip to Devil's Head Resort, Merrimac, WI on Feb. 4 & 5, 2011**. I understand that transportation for this trip will be by private and rented vans and cars. All persons driving these vehicles are insured, licensed drivers over the age of twenty-five.

Child's **GIVEN** name \_\_\_\_\_

Gender \_\_\_\_\_ Date of Birth (month/date/year) \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Parent Cell Phone \_\_\_\_\_

Child's email \_\_\_\_\_

Parent's email \_\_\_\_\_

Emergency Name and Phone \_\_\_\_\_

List of known allergies: \_\_\_\_\_

List of regularly taken medication & dietary supplements: \_\_\_\_\_

\_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

Insurance Information:

Name of Health Insurance Company \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Phone Number of Insurance Company \_\_\_\_\_

I further understand that, in the event my child requires medical or dental treatment on this trip reasonable efforts will be made to contact me; however, if I am unable to be reached, I here by consent and give permission to any adult advisor on this trip to seek any medical or dental assistance for my child .

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relation to child \_\_\_\_\_

IF THE PARTICIPANT IS UNDER AGE 18,  
ALL MEDICATIONS MUST BE GIVEN TO THE APPOINTED ADULT AND ADMINISTERED BY THE ADULT.

Over-the-counter medication such as Advil, cough medicine and Imodium, for example, may be given to your child as needed, unless you specify otherwise.

A. \_\_\_\_\_ Do not give any over-the-counter medicines.

B. \_\_\_\_\_ OK to give over-the-counter medicines.

Parent contact needed prior to administration \_\_\_\_\_yes \_\_\_\_\_no

C. \_\_\_\_\_ OK to give over-the-counter medicines except for the following: \_\_\_\_\_

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Does your son/daughter wear contact lenses? \_\_\_\_\_yes \_\_\_\_\_no

For females only: has menstruated \_\_\_\_\_ yes \_\_\_\_\_no

Are there any other concerns regarding your child that would be helpful for the adult chaperones to know?

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Activities that child may not participate in: \_\_\_\_\_

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