

**TRIP PERMISSION FORM and
UNCONDITIONAL RELEASE OF LIABILITY, August 2008 – August 2009**

The undersigned does hereby give permission for my son/daughter, _____, to attend and participate in off-site activities sponsored by St. Timothy's Episcopal Church, including but not limited to, Sunday evening EYC trips, overnight retreats, outreach events, fellowship outings, and mission trips. I am familiar with the hazards of highway travel and further understand the potential hazards of youth trips in general. I recognize the potential hazardous nature of the activities in which my son/daughter may engage.

I hereby unconditionally release and absolve St. Timothy's Episcopal Church and all clergy, staff, and volunteer leaders involved in these activities from liability for any accident.

In case of emergency, I understand that every effort will be made to secure proper treatment. I hereby give permission for such treatment and consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician, dentist or licensed hospital whether such diagnosis or treatment is rendered at the office of said physician/dentist or at said hospital. My personal health and accident insurance covers any accident or illness that may be incurred during this experience. I will personally guarantee any cost of other liability incurred during evacuation or treatment.

I consent to the use of any visual or audio reproduction that may be taken of the above named student during EYC sponsored activities to be used, distributed, or shown as St. Timothy's Episcopal Church sees fit, including being posted on St. Timothy's Website (for advertising youth activities).

Parent's Signature

Date

Parent's Signature

Date

Student Signature

Date

In case of any illness or injury, contact:

Name

Phone

Address

(PLEASE SIGN REVERSE SIDE)

HEALTH INVENTORY, Aug. 2008 – Aug. 2009

Youth Name _____ Male ___ Female ___ Birth date _____

Address _____ City _____

State _____ Zip Code _____ Home Phone _____

Cell Phone _____ School Grade _____

Youth Email _____ Parent Email _____

Parent/Guardian Information:

1. Name _____ Contact Phone _____

2. Name _____ Contact Phone _____

Insurance Company _____

Insurance Policy Number _____

Date of last physical exam _____ Date of last tetanus booster _____

Doctor's Name _____ Telephone _____

Dentist's Name _____ Telephone _____

Hospital Preference: Baptist _____ Forsyth _____ Other _____

DO YOU HAVE:

Allergies? _____ NO ___ YES Specify _____

Asthma? _____ NO ___ YES Specify _____

Bee Sting Allergy? _____ NO ___ YES Specify _____

Diabetes? _____ NO ___ YES Takes Insulin ___no ___yes

Ear Infections? _____ NO ___ YES Specify _____

Epilepsy/Seizures? _____ NO ___ YES Specify _____

Heart Conditions? _____ NO ___ YES Specify _____

Orthopedic Problems? _____ NO ___ YES Specify _____

Other Problems? _____ NO ___ YES Specify _____

HAVE YOU HAD:

Serious Illness? _____ NO ___ YES Specify _____

Serious Injury? _____ NO ___ YES Specify _____

Surgery? _____ NO ___ YES Specify _____

Childhood Diseases? _____ NO ___ YES Specify _____

DO YOU:

Take daily medication? ___NO ___YES Specify _____

Take emergency medication? ___NO ___YES Specify _____

Have permission to take, if needed: Tylenol/Ibuprofen ___NO ___YES

Pepto-Bismol ___NO ___YES

Do you have any special dietary concerns or needs? _____

(PLEASE SIGN REVERSE SIDE)