

## Youth Permission/Medical Release

Youth Name: \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Grade \_\_\_\_\_

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

\_\_\_\_\_

I give permission for my son/daughter to participate in the Dream, Discover, Discern retreat at Mt. View Lutheran Church, Edgewood WA. In case of emergency, I understand that every effort will be made to contact me. If I cannot be reached, I hereby give the designated sponsor permission to act in my behalf in seeking emergency treatment for my son/daughter, in the event that such treatment is deemed necessary by designated sponsor. I give permission to those administering emergency treatment to do so, using those measures deemed necessary.

Parent/GuardianName(s)(printed): \_\_\_\_\_

Signature \_\_\_\_\_

Parent's Home Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

Emergency contact (other than parent): \_\_\_\_\_

Relation to Youth: \_\_\_\_\_

Emergency Home Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

Name of family doctor: \_\_\_\_\_

Phone # \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Contract Number: \_\_\_\_\_

List any allergies: \_\_\_\_\_

\_\_\_\_\_

List any current medical problems or medicines:

\_\_\_\_\_

\_\_\_\_\_