



Permission Form for Emergency Medical Treatment

Student's Full Name: _____
(Last, First, MI)

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Birthday: _____ (Month/Day/Year)

High School Graduation Year: _____ Church Name: _____

Insurance Company: _____

Insurance Policy Number: _____

Food/Medicine Allergies: _____

If you are under 18 years of age, have a parent or guardian sign below.

In the event of an emergency, I give permission for my son/daughter to receive medical treatment.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Parent/Guardian Phone Number: (____) _____ Date: _____

This medical form must be submitted at check-in in order to finalize your registration.