

CROSS WALK YOUTH PERMISSION SLIP
2023-2024

I give my child, _____, permission to participate in all Youth Ministry activities, trips, and programs sponsored by:
First Methodist Church Bridgeport.

General Information

Child's name: _____ Birthday: ___/___/_____

Address: _____
(Street) (City) (Zip)

Home Phone#: _____ Child's Cell#: _____

School attending: _____ Grade level: _____

Legal guardian #1: _____ Cell#: _____

Legal guardian #2: _____ Cell#: _____

I understand that the chaperones will use their best efforts to supervise; however, I also understand they are not responsible for loss of personal property or bodily injury.

Signature of Parent/Guardian: _____

Date: ____/____/_____

During youth events, there will be photos taken for church use on the web site and/or slideshows. Will you give us your permission to use these photos of your child, knowing that your child's name will not be attached to these photos.

I give permission for First Methodist Bridgeport to use my child's photo on the youth Instagram page and/or the church Facebook page:

Signature of Parent/Guardian: _____

Date: ____/____/_____

(Please fill out the medical information on the reverse side of this page)

Medical Information and Emergency Release

In the event my child becomes ill, is injured or requires emergency medical attention of any kind, and I cannot be reached by phone, I authorize the adult chaperone(s) to make the necessary decision concerning emergency treatment. I also give permission for my child to be transported to the nearest medical facility or hospital for treatment. I understand that I will assume full responsibility for the payment of services rendered.

Parent/Guardian Signature: _____

Date: ____/____/_____

If a parent cannot be reached, please contact the emergency person listed below.

Contact: _____ Home #: _____

Cell #: _____ Relationship _____

My child's last Tetanus shot was administered on: _____

My child's allergies to medications are: _____

My child's other allergies are: _____

The medications my child takes on a regular basis are: _____

Other information about my child that should be known to healthcare providers is:

Name of Child's Physician: _____

Physicians Office #: _____

Medical Insurance Company: _____

Phone #: _____

Policy #: _____ **Group #:** _____