

PERMISSION SLIP/WAIVER IN LIEU OF HEALTH EXAMINATION
(Please fill out the reverse side and include a copy of your insurance card)

I hereby give permission for _____
Last Name First Name Social Security #

Address: _____
Street City Zip Code

Primary Phone: _____ Emergency Contact and Number: _____

to participate in the United Methodist enterprise ("enterprise") for which he/she is enrolled, and do not hold the enterprise or the **Simpsonwood United Methodist Church**, any of their representatives, staff or officers (to include officers, etc. of enterprise) responsible for sickness, injury or death resulting from any physical unfitness of my child to participate in the enterprise activities. In case of medical emergency, I understand every effort will be made to contact a parent or guardian. The information provided on the reverse side of this card regarding my child's medical history and condition is complete and correct to the best of my knowledge. In the event I cannot be reached, I hereby give permission to the physician selected by the **Simpsonwood United Methodist Church** staff, representatives, or officers to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for my child, as named above.

Signature of parent or guardian

Subscribed and sworn to before me this ____ day of

STATE OF GEORGIA
COUNTY OF _____

(month and year)

My Commission expires: _____

NOTARY PUBLIC

Please attach a copy of your insurance card

Participant's Doctor: _____
Name Address Phone

Participant's Birthdate: ____/____/____ Participant's Height: _____ Weight: _____

Parent's or Guardian's Address: _____
Street

City

Zip Code

Primary Phone: _____ Parent's or Guardian's Social Security #: _____

Medical History

1. Is there a history of chronic infection of nose, throat, ears, sinus or lungs: _____
If so, what? _____
2. Is there a history of heart pathology requiring restricted activity? _____
3. Is this person subject to any skin disease? _____
4. List allergies to drugs, medications or food: _____
5. Has there been recent illness or exposure to contagious disease? _____
If so, what? _____
6. Is this person subject to any of the following (circle all that apply):

Fainting Convulsive Seizures Diabetic Nose Bleed Cramps Asthma

What medications are prescribed for the preceding conditions? _____

7. Limitations of activity: _____
8. Please list any drug or medications to be taken regularly _____
9. Date of last tetanus shot: _____