

# PARENTAL CONSENT/MEDICAL RELEASE FORM

NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

CELL PHONE'S \_\_\_\_\_

HOME PHONE \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT (S)/GUARDIANS BUSINESS/CELL PHONE NUMBERS \_\_\_\_\_

EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN) \_\_\_\_\_ PHONE \_\_\_\_\_

To Whom It May Concern:

The undersigned does hereby give permission for \_\_\_\_\_ to participate in the following activity  
(Child's Name)

sponsored by Our Lady of the Lake Parish

<b>ACTIVITY:</b>	<b>Holland Family Hope – Stepping Stones Day Care</b>
<b>COST:</b>	<b>Free</b>
<b>WHEN:</b>	<b>Monday's 12:30-2:15 pm 6/23, 6/30, 7/7, 7/14, 7/21, 7/28, 8/4, 8/11 and 8/18</b>
<b>WHERE:</b>	<b>Family Hope Ministry Center 356 Fairbanks Avenue , Holland MI 49423 616.396.2200</b>
<b>TRANSPORTATION:</b>	<b>By parents ADULT CHAPERONES: Yes, _____</b>
<b>DESIGNATED SUPERVISOR:</b>	<b>Mary Murphy (616) 901.5579 Coordinator of Youth Ministry</b>

In consideration of my child being allowed to participate in this Day Care Service, I hereby agree on behalf of myself and my child, to release Our Lady of the Lake Church, the Roman Catholic Diocese of Grand Rapids, and any and all affiliated organizations, their employees, agents and representatives, including volunteer drivers (collectively "Releasees"), from any and all claims, including negligence, which may be asserted by me or my child, or on behalf of my child, arising from or relating to my child's participation in the mission trip.

We(I) authorize an adult, in whose care the minor has been entrusted, to 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 licensed physician or licensed dentist on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume responsibility for transportation and/or incurred transportation costs.

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent(s)/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Below please list any allergies or special medical problems your child may have.

\_\_\_\_\_

Please list any medications your child is currently taking.

\_\_\_\_\_

**\* Bring permission slip with you to Stepping Stones Day Care at Holland Family Hope Attn. Mary Murphy!**