Medical Permission Slip

Child Evangelism Fellowship® of Nebraska, Inc.
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Emergency Numbers at CYIA '19 North
Faith Regional Physician Services Laurel Family Medicine • 318 E 2nd St., Laurel, NE 68745 • (402) 256-3042
Providence Medical Center • 1200 Providence Rd., Wayne, NE 68787 • (402) 375-3800

This form is valid for all Child Evangelism Fellowship functions from **January 1, 2019 to December 31, 2019**. **It must be completed in full, signed and *NOTORIZED***. If the person is under age 19, the parent/guardian must sign below.

Student's Name_____________________________ Phone (_______)__________________

Address____
Street City State Zip

Birth Date___/___/___ *Age ___ Fax (_____) _________ E-mail_____________________
*For those under 19 years old.

Social Security Number ________________________ Cell phone ________________________

Medical Information

Please provide any medical information that would help.

Allergies____

Medication(s) taken ____

Physical limitations ____

Any other medical condition we should be aware of, such as asthma, epilepsy, etc.______________________

____

Medical Insurance Company ____

Policy Holders Name ______________________________Policy # __________________

Parent's Doctor _________________________________ Phone # __________________

Student's Doctor ________________________________ Phone # __________________

EMERGENCY PHONE NUMBERS

Parent/Guardian Name ________________________ Home Phone __________ Work ___________ Cell___________

Other person to contact ________________________ Home Phone __________ Work ___________ Cell___________

Medical Release

I give permission for ___________________to participate in CEF's activities from *Jan. 1, 2019 to Dec. 31, 2019*. **I hereby release CEF, its staff and sponsors from responsibility and liability for any illness or injury the above-named person may sustain during activity. In the event of an emergency, I hereby authorize an adult leader of the activity, as an agent for me, to consent to any X-ray, examination, medical, dental, anesthetic or surgical diagnosis; treatment; and hospital care advised and supervised by a licensed physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are to be rendered, either at the physician's office or in a hospital. I understand the activity director will endeavor to reach us should the nature of the injury or illness warrant it. However, we will not hold any activity personnel responsible if efforts to contact me (us) are unsuccessful.**

____
Signature of parent/guardian

State of _________________)
) ss
County of _______________)

The foregoing instrument was acknowledged before me this ____ day of

______________________, 20___ by ______________________________.
(Printed Name of Parent/Guardian)

(Seal)

____
(Signature of Notary Public)