Medical Permission Slip

Child Evangelism Fellowship® of Nebraska, Inc.
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Emergency Numbers at CYIA '20 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, 2020 to December 31, 2020**. **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, 2020 to Dec. 31, 2020***. 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)