

Child's Name _____ Grade _____

PERMISSION SLIP FOR ANY CHURCH-RELATED FUNCTION AND CONSENT FOR MEDICAL TREATMENT

The undersigned hereby gives permission for _____ to attend any church-related function of Living Streams Church. In the event there is an emergency involving your child, permission is hereby granted for Living Streams Church personnel to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in any state, and to consent to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care to be rendered to the minor by any dentist licensed to practice in any state, and church personnel shall not be held personally liable. This consent for any church-related function and medical treatment shall terminate on the 18th birthday of said minor which is ____/____/20____, or unless otherwise revoked by parent or legal guardian in writing.

Signature of Parent or Legal Guardian
(sign in presence of Notary Public)

Address

City State Zip

(_____) _____
Area code & phone

STATE OF ARIZONA, COUNTY OF MARICOPA

Subscribed and sworn to before me

this _____ day of _____, _____

by _____
(print your name)

Notary Public: _____

My Commission Expires: _____

Photography permission:

____ I hereby grant Living Streams Church permission to use photographs which include my child in any and of its publications and in any and all other media, whether now known or hereafter existing, controlled by Living Streams Church in perpetuity and for other use by the Church. I will make no monetary or other claim against Living Streams Church for the use of the photograph/video.

____ I do not want my child's photograph to be used in any publications or other media controlled by Living Streams.

Emergency Contact Information:

Child's Name: _____ Date of Birth: _____

Parent's Name: _____

Home Phone: _____ Work: _____ Cell: _____

Nearest Relative/Neighbor _____ Phone: _____

Family Insurance Number: _____ Insurance Company: _____

Date of last tetanus shot: _____

Date of last measles shot: _____

Does your child take any regular medicine: _____ If so, what: _____

Does your child have any allergies: _____ If so, what: _____

