2015

Crosspointe Permission Form

Parents: This form gives consent for your child/student to participate in every event and/or activity sponsored by Crosspointe Baptist Children and/or Student Ministry for the year 2015.

STUDENT INFORMATION

Student Name_____

Date of Birth (MM/DD/YYYY) _____ Grade _____

Address:_____

City_____ State_____

GUARDIAN INFORMATION

Name _____ Relationship_____

Primary Phone:_____ Secondary Phone _____

Email_____ @ _____

Address (if different from student):_____

City_____ State_____

EMERGENCY CONTACT INFORMATION

Contact 1 _____

Relationship_____ Phone _____

Contact 2 _____

Relationship_____ Phone _____

I, the undersigned, do hereby verify that the above information is correct and I do hereby release and forever discharge all leaders, staff, and Crosspointe Baptist Church from any and all claims, demands, actions or cause of any action, past, present, or future arising out of any damage or injury while traveling or participating in Crosspointe Children and/or Student Ministry sponsored events. Furthermore, I acknowledge that my child/student's failure to comply with the policies outlined in the Crosspointe Children and/or Student Ministry handbook may result in suspension from attending future ministry events.

Guardian Signature _____ Date _____

2015

Medical Release (Authorization for Emergency Medical Treatment)

I, _____
guardian name

of _____ city of _____, County
address *city*

of _____ State of Kentucky, am the father/mother/legal guardian of
county

_____, a minor of,
child name

_____, city of_____, Kentucky,
address *city*

who attends and/or participates in activities with Crosspointe Baptist Church, located at 550

Worthington Road, Owensboro, Daviess County, Kentucky 42301.

In the event that all reasonable attempts to contact me at the phone numbers listed on the reverse side of this form have been unsuccessful, I hereby give my consent for:
(1) The administration of any treatment deemed necessary by any licensed physicians or dentist;
(2) The transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained prior to the performance of such surgery.

Date_____Signature_____

Print Name _____

Witnessed by _____ Date _____

Student Medical Information

Allergies: _____

_____

Medication being taken:_____

Date of last tetanus shot:_____ Physical Impairments:_____

Insurance Information

Primary Physician _____ Physician phone _____

Insurance Company:_____

Policy Number:_____ PolicyHolder:_____

(Optional provide copies of insurance cards)