KIDS IN CHRIST
PERMISSION SLIP & HEALTH FORM

Date ___________________________

Child's Name (Last, First) ____

Child's Age __________ Child's Date of birth _______________

Street address ____

City ______________________ State _____ Zip _____________ Phone ____________________

Who to contact in case of an emergency:

Parent/Guardian Name ____

Street address ____

City ______________________ State _____ Zip _____________

Home # ___________________ Work # ____________________ Cell # ___________________

The above named child has permission to leave Farmington Lutheran Church premises for KiC (Kids in Christ) activities. I also give permission for my child to travel with parents and chaperones who are designated to drive for these off site activities.

If I cannot be reached in the case of an emergency, I authorize Farmington Lutheran Church as temporary guardian to obtain any medical or surgical care deemed necessary in the emergency room for my child. I grant permission for the emergency room doctor, or whom the doctor designates, to care for my son/daughter.

x____

(Parent or Guardian signature) (Date)

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Emergency Medical Information

1. What diseases has he/she had? (Check appropriate places)

____ measles ____ tonsillitis ____ trench mouth
____ mumps ____ rheumatic fever ____ head lice
____ bronchitis ____ impetigo ____ pneumonia
____ scarlet fever ____ whooping cough ____ infantile paralysis
____ undulant fever ____ chicken pox ____ meningitis

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2. Has he/she had any serious illness in the past year? Yes ____ No ____

   What? ____

3. Has he/she had any physical disability? Yes ____ No ____

   What? ____

4. Does he/she have any allergies? Yes ____ No ____

   What? ____

5. Does he/she take medicine? Yes ____ No ____

   What? ____

6. Has he/she had a tetanus shot? Yes ____ No ____

   When? ____

7. Is your child subject to (check appropriate places)

   ____ Headache
   ____ Nose Bleeds
   ____ Draining ears
   ____ Hay fever
   ____ Asthma
   ____ Sinus infection
   ____ Motion Sickness
   ____ Indigestion
   ____ Constipation
   ____ Fainting
   ____ Spasms

8. Do you have any health insurance? Yes ____ No ____

   Insurance Company ____________________________________

   Policy number ____

9. Is there anything else you think we should know?

   ____

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