

# Good Shepherd Lutheran Church

## For activities through May 2012

504 South Main Street, Viroqua, WI 54665 (608) 637-3978

[office@gsviroqua.org](mailto:office@gsviroqua.org) [www.gsviroqua.org](http://www.gsviroqua.org)

### CONSENT AND RELEASE FROM LIABILITY

\_\_\_\_\_ has my permission to participate in all activities of Good Shepherd Lutheran Church through May 31, 2012 and to be transported by church bus or private car when necessary. I understand all events will have adult supervision. In consideration of the benefits to be derived from these activities, I hereby voluntarily waive any claim against Good Shepherd Lutheran Church, the sponsors, and the owner/or driver of the car or bus furnishing transportation to and/or from any event. I further agree to direct my son/daughter to conform to the fullest with the directions and instructions of the sponsors in charge. This consent and release is in effect until May 31, 2012, or until I give Good Shepherd Lutheran Church written notice to the contrary.

Parent/Guardian signature: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ email: \_\_\_\_\_

Date: \_\_\_\_\_

### MEDICAL CARE PERMIT

I hereby authorize emergency medical care or first-aid treatment as needed for my son/daughter, \_\_\_\_\_, in the event of illness or injury during any sponsored activity of Good Shepherd Lutheran Church. This permit is in effect until May 31, 2012, or until I give Good Shepherd Lutheran Church written notice to the contrary.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Insurance company's emergency phone: \_\_\_\_\_

### EMERGENCY INFORMATION

	Parents	Nearest Relative	Neighbor
Name			
Address			
Phone			

Please print (use the back of the form if necessary)

Has he/she had any surgery or serious illness within the last 3 years? \_\_\_yes \_\_\_no. If yes, explain:

Is he/she required to take any medication? \_\_\_yes \_\_\_no. If so, for what reason and how often?

Does he/she have any allergies or allergic reaction to any medication? \_\_\_yes \_\_\_no. If yes, explain.

Is he/she presently under a doctor's care? \_\_\_yes \_\_\_no. If yes, explain.

*Revised, February 21, 2011--Print 2012 year's on the color GREEN*