

# Trinity United Methodist Church

## PARENTAL PERMISSION AUTHORIZATION FORM

**Event Name:** \_\_\_\_\_

**Place:** \_\_\_\_\_

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

**Participant Name:** \_\_\_\_\_

**Birth date:** \_\_\_\_\_

I give permission for my child to attend the Trinity United Methodist Church event listed above. I further give permission for my child to be transported to and from the event by hired and volunteer drivers authorized by Trinity United Methodist Church.

### **Medical Release**

I authorize the medical and or dental treatment of my child by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

### **Custody Release**

I further authorize the Director(s) of Youth and Family Development or a designated adult representative of Trinity United Methodist Church to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to said adult.

### **Activity Release**

I further give permission for my child to participate in all supervised activities except as noted:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Printed name of Parent or Guardian

\_\_\_\_\_  
Date

Parent Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Health Care Information**

**Physician**

**Dentist**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Medical Insurance Company

\_\_\_\_\_  
Dental Insurance Company

\_\_\_\_\_  
Policy Group Number

\_\_\_\_\_  
Policy Group Number

\_\_\_\_\_  
Name of Policy Holder

\_\_\_\_\_  
Name of Policy Holder

Allergies: \_\_\_\_\_

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