Medical Release and Permission Form Jan 2025- Jan 2026

I/We,_____, am the parents and/or guardians of,_____.
(Print Name) (Print Name)

And I hereby give permission for_____to participate in the activities that will take place on this Clarksville Highway Church of Christ, 5444 Highway 41A, Joelton, TN, sponsored trips for Jan 2024-Jan 2025.

I/We the Parents and/or guardians agree to not hold Clarksville Highway Church of Christ and/or its representatives in said activities from any and all liability relating to said child for any personal injury or illness and/or error or omission, that may be suffered or any loss of and/or damages to property that may occur to said child arising out of the care and custody of said child during the participation of the trip. In event that said child must be sent home due to disciplinary and/or medical reasons I/We agree to pay the expenses that Clarksville Highway Church of Christ incur by sending said child home.

In the event that my child becomes ill or sustains an injury while in the custody of Clarksville Highway Church of Christ and it's representatives, I would like to be contacted first before actions are taken, if the time permits and doesn't put the health and well being of my child at risk. If such time does not exist: I/WE VOLUNTARILY GIVE PERMISSION THOSE IN CHARGE TO TAKE WHATEVER STEPS NECESSARY TO ADMINISTER EMERGENCY FIRST AID, AND FURTHER VOLUNTARILY GIVE MY PERMISSION FOR MY CHILD TO RECEIVE EMERGENCY MEDICAL/ SURGICAL/ DENTAL CARE AS DEEMED NECESSARY BY ANY DULY LICENSED PHYSICIAN/PRACTITIONER, TO ADMINISTER NECESSARY TREATMENT REQUIRED FOR THE RELIEF OF PAIN AND TO PRESERVE HIS / HER LIFE AND HEALTH. I VOLUNTARILY AUTHORIZE THE EMERGENCY MEDICAL/SURGICAL/DENTAL TREATMENT OF MY CHILD AT SAID PHYSICIAN'S OFFICE, OR AT A LICENSED MEDICAL HOSPITAL.

Allergies and/or medical conditions: _____
Any Medications:_____D.O.B:____/____/_____
Parents/Guardians:_____Home Phone: _____
Address: _____Cell Phone: _____
City: _____
State: _____ Zip Code: _____ Work Phone: _____

Insurance Carrier: _____ Insurance's Phone#: _____

Policy #: _____ Group #: _____ Preferred Hospital:_____

Physician Name: _____ Physician's #:_____

Dentist Name: _____ Dentist's #: _____

In Case of Emergency and you cannot be reached, call: _____

Phone #:_____

Date of last Tetanus Shot: ____/____/_____

Signature: _____

Rules of Conduct – That we expect each student to conform to…

- No possession or use of alcohol, drugs, or tobacco
- No PDA (Public Displays of Affection)
- No sneaking away from the group to display that affection either
- No student may drive
- Seatbelts are required at all times in all vehicles.
- No fighting, weapons, fireworks, lighters, or explosives
- No offensive or immodest clothing
- No boys in girl's sleeping quarters and no girls in boy's sleeping quarters
- Everyone is expected to participate in the activities of the event
- Respect all property
- Respect one another, staff, and adult leaders
- Respect and comply with the event schedule

*Parent's Signature:_____Date____/___/_____

*Student's Signature:_____Date:_____/___/_____

1. For your student's safety and our knowledge, is your student a ….

Good Swimmer Fair Swimmer Non-Swimmer
(Circle One)

2. Does your student suffer from , or has ever experienced, or is being treated currently for any of the following….

	(Circle One)	(Specialized Instructions)
a. Asthma :	Yes or No	_____
b. Epilepsy/ Seizures	Yes or No	_____
c. Heart Troubles	Yes or No	_____
d. Diabetes	Yes or No	_____
e. Freq. Upset Stomach	Yes or No	_____
f. Physical Handicap	Yes or No	_____
g. Other	Yes or No	_____
		_____

3. Should this student's activities be restricted for any reason? Please Explain:

_____
_____
_____
_____
_____
_____