



PARENT PERMISSION FORM

I/We, the parents/guardians of the student named below, understand the nature of the trip being planned to

Event: _____ **Date:** _____ **Time:** _____

We understand that transportation will be by: The Crossroads volunteers via the church van and personal vehicles and we are in accord with the purposes of and procedures governing the trip. We hereby grant permission for our son/daughter to participate. We understand that adequate and appropriate supervision will be provided. We recognize, however, that unanticipated situations and problems can arise on any trip, church-sponsored or otherwise, which situations or problems are not reasonably within the control of the supervising volunteer(s) or staff. We further agree to release and hold harmless Crossroads Church and the Crossroads management team, and Crossroads staff/volunteers, from any and all liability, claims, suits, demands, judgments, costs, interest and expense (including attorneys' fees and costs) arising from such activities, including any accident or injury to the student and the costs of medical services.

In the event of an injury requiring medical attention, I hereby grant permission to the supervising volunteer(s) or staff to attend to my son/daughter. If the injury warrants further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for necessary medical treatment to be given. In addition, I hereby give my permission to the supervising volunteer(s) or staff to take my child to the physician, dentist, or to the hospital if an accident or serious illness occurs on the trip and I cannot be located.

In the event that a student must return to Crossroads independently for reasons of health, accident, failure to conform to rules established by the staff or volunteer in charge, etc., we agree to accept full responsibility for and to pay for the cost of medical care, transportation and other incidental expenses.

Student

Parent or Guardian (Please print) Parent or Guardian (signed) Date

Home Phone _____ **Work Phone** _____

Cell Phone _____

Please check below IF your child has sensitivity to:

Bee Sting Nuts Dairy Latex Other _____

Required medications: _____

Please check below IF your child has:

Asthma Diabetes Kidney Injuries Seizure Disorder Heart Condition Other

Medical Condition

Medications: _____

If the student requires medication, I understand that I am obligated to ensure that the medication and the Medication Authorization Form are on record in the Church Office.