



**ACTIVITY PERMISSION SLIP**  
**And Authorization for Medical Treatment**

*Please Print to Complete the Following:*

Student's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Cell: \_\_\_\_\_ Father's Cell: \_\_\_\_\_

Additional Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

It is the hope of VVCC's Student Ministry that all sponsored activities run without any difficulties. The following guidelines exist to ensure a problem-free trip for all involved:

- Students are to conduct themselves in a manner reflecting the values of Victor Valley Christian Church.
- Students are to never leave the area where the group is, or where the activity is taking place.
- Students are to be aware of and follow the instructions given by the adults leaders they are with.

Failure to follow any of these guidelines will result in one or more of the following:

- A loss of privilege for the remainder of the trip or activity.
- An additional disciplinary responsibility to be carried out for the remainder of the trip or activity.
- A collect phone call (regardless of hour) to discuss the situation with the parents.
- The sending of the student home before the end of the trip or activity **at his/her expense**.

I have read the above and am willing in the interest of all involved to submit myself to the conditions stated.

\_\_\_\_\_

student's signature

\_\_\_\_\_

date

I have read the above and agree to hold my student accountable to the conditions stated. I believe the necessary precautions and plans for the care and supervision of the students during this activity will be and have been taken. Therefore, I release and discharge Victor Valley Christian Church, a California Corporation, its agents, employees, and all officers from claims, demands, judgments, and executions for all personal injuries, known or unknown, and injuries to property, real or personal, caused by, or arising out of the activities afforded my minor child by Victor Valley Christian Church.

\_\_\_\_\_

parent/guardian signature

\_\_\_\_\_

date

**Please complete both sides of this form**

(I)(We), the undersigned parent(s)/person having legal custody/ legal guardian of \_\_\_\_\_, a minor, do hereby authorize Victor Valley Christian Church, and its agents as representative for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and the hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority to power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which a physician meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

(I)(We) hereby authorize any hospital which has provided treatment to the above named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to (my) (our) above named agents upon the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California. I understand that this form is intended only for instances when an unforeseen medical emergency arises and I am not available to give consent.

These authorizations shall remain effective for 30 days from the date of signature unless sooner revoked in writing delivered to Victor Valley Christian Church.

\_\_\_\_\_ parent/legal guardian signature \_\_\_\_\_ date

**Medical Information for** \_\_\_\_\_ :  
Minor's Name

ALLERGIES: \_\_\_\_\_

CHRONIC ILLNESSES: \_\_\_\_\_

PHYSICAL LIMITATIONS/RESTRICTIONS: \_\_\_\_\_

DATE OF LAST TETANUS SHOT: \_\_\_\_\_

SPECIAL MEDICATIONS: \_\_\_\_\_

OTHER IMPORTANT INFORMATION: \_\_\_\_\_

MINOR'S PHYSICIAN: \_\_\_\_\_

PHYSICIAN'S PHONE NUMBER: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

INSURANCE POLICY NUMBER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

RELATIONSHIP TO MINOR: \_\_\_\_\_

EMERGENCY PHONE NUMBER: \_\_\_\_\_