Permission Slip/Liability Waiver

As the parent or legal guardian of _____, I am in complete understanding that my son/daughter is participating in this _____ activity sponsored by **Trinity Lutheran Church**. I fully understand and choose not too, and will not hold the above named Church, any of their **agents, assigns, employees, or volunteer sponsors** (hereafter all referred to as **sponsors**) liable for any accidents, injuries, or any other unforeseen harms incurred at any time while participating in this activity, except in the case of gross negligence. I authorize Trinity Lutheran Church**,** and their sponsors to find adequate and reasonable medical treatment at my expense, if the need arises. ***This waiver will serve as a medical release form.***

Additionally, I understand that if my son/daughter engages in any known or unknown illegal activities at any time while participating in the activity, Trinity Lutheran Church and their sponsors, will not be liable for any damages or problems he/she may cause, and will not be liable to perform any legal defense on their behalf. I also understand that if any problems do arise, my son/daughter may be sent home, at my expense, on the first available means of transportation, at the sponsor's discretion. The parent/guardian will be contacted before and if this action becomes necessary.

I understand that by signing below, as the parent or legal guardian, I agree to and will adhere to the preceding statements and grant permission for my child to participate in this activity. (Signing below does not nullify your rights granted to you by local, state, and federal laws) Also, I understand that my child will not be allowed to participate if this completed form does not accompany them before this activity begins.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE DATE PHONE NUMBER

_____

_____

ADDITIONAL INFORMATION

Please give your child's insurance information below. This information will only be used if a situation warrants medical attention. If we do not have this information we will still seek medical treatment, but the billing issues will need to be settled between you, the insurance provider, and the medical provider.

_____

Insurance Provider Name **Policy Number**

_____

Insured's Name **Group Number (if applicable)**

_____

_____

_____

MEDICATIONS BEING TAKEN; OTHER HEALTH ISSUE INFORMATION