St. Matthew Lutheran Church
Parental Permission Slip

Youth Name _____

Address _____

_____

Phone _____

Birthday _____ Grade _____

Can you, the parent/guardian, be reached at the above number during the time your child will be gone? _____ If not, where can we reach you? _____

Address _____ Phone _____

In case of emergency, if you cannot be reached, whom should we contact?

Name _____ Phone _____

Does your child have any health problems we should be aware of? (asthma, allergies, diabetes, heart condition, etc.) If so:

1. Name _____
2. Treatment _____
3. Dosage _____
4. Time to take _____
5. Special instructions _____

Health Insurance Company _____
Policy/Group Number _____

I _____ grant _____ from St. Matthew
(parent) (counselor)
Lutheran Church, permission to authorize medical treatment to _____
(youth)
in case of emergency.

_____ _____
Parent Signature Date

Come, Enjoy, and Have a Great Time!