

# Calvary Lutheran Church & Christian Nursery School

165 W. Crescent Avenue  
Allendale, New Jersey 07401  
201-327-4786

## **PERMISSION SLIP**

I, \_\_\_\_\_, give my permission  
[Parent/Guardian Name, PLEASE PRINT]

for \_\_\_\_\_ to participate in the \_\_\_\_\_.  
Youth's Name, [PLEASE PRINT] Event Name, [PLEASE PRINT]

that will be held on \_\_\_\_\_.  
Event Date, [PLEASE PRINT]

In the event of an emergency, I hereby authorize an adult leader of the Hi League Youth Group as agent for me, to consent to any X-ray examination; medical, dental or surgical diagnosis; treatment; and hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) licensed to practice under the laws of New Jersey where the services are rendered, either at a doctor's office or in any hospital. I expect to be contacted as soon as possible.

SIGNATURE: \_\_\_\_\_  
Parent or Guardian

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## CONSENT FOR MEDICAL TREATMENT OF MINOR

As a parent/or guardian a potential problem exists in the event your child requires medical treatment and you are not available to give consent. In order to avoid possible delays in necessary treatment as a result of not being able to contact you, your signature on this completed form will provide the hospital with written consent to provide immediate treatment.

Child's Name: \_\_\_\_\_ Age \_\_\_\_\_ Birth date: \_\_\_\_\_

Medications Child is taking: \_\_\_\_\_  
\_\_\_\_\_

Allergies (include all known allergies; i.e. food, drugs): \_\_\_\_\_  
\_\_\_\_\_

Special medical problems (include heart, lung, diabetes history): \_\_\_\_\_  
\_\_\_\_\_

Date of last Tetanus \_\_\_\_\_ Are immunizations up to date? \_\_\_ Yes \_\_\_ No

Name of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Work Hours \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Work Hours \_\_\_\_\_

Family Physician \_\_\_\_\_

Office Phone \_\_\_\_\_

Emergency number and other person to contact: \_\_\_\_\_  
\_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number \_\_\_\_\_ Policy Holder: \_\_\_\_\_

**MEDICAL TREATMENT AUTHORIZATION:** In case of a medical need involving the minor listed, I request the hospital staff to contact me (or my spouse) at the numbers provided. In the event that I (or my spouse) cannot be reached, I grant written permission to the hospital's emergency medical staff to render medical care as deemed appropriate. I (We) agree to pay for the normal and customary charges of the hospital for any treatment or medication received by said child. I also agree to notify the hospital in writing if I cease to be guardian or if there are any changes in the above authorization.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date