



Permission Slip and Medical Consent Authorization Form

Las Flores Church of the Nazarene \* 1400 Las Flores Dr. \* Carlsbad, CA 92008

(We) I the undersigned parent(s) or legal guardian(s) of: NAME: \_\_\_\_\_

(Please print minor's name.)

a minor, do hereby authorize representatives of the LAS FLORES CHURCH OF THE NAZARENE, Carlsbad, California, as agent(s) for the undersigned, to consent to any emergency diagnostic procedure and any medical or surgical treatment required and deemed advisable by any duly licensed physician and surgeon, or under this or her general or special supervision. It is understood that this authorization is being granted for emergency medical and/or surgical care only, and that all usual means shall be used to notify the undersigned prior to commencement of any major procedure. It is understood that such specification shall not prohibit the institution of such emergency care as is necessary to preserve the life of the above minor.

We (I) further do attest approval of this authorization and do certify as to its correctness, expressly waiving any and all claims against the LAS FLORES CHURCH OF THE NAZARENE, Carlsbad, California, or any of its Boards or representatives because of the injury or other damage that may be incurred to the above minor or said minor's property in connection with any incident during the trip.

Further, I hereby grant permission for the above name child to participate in the DISCIPLESHIP BACKPACKING TRIP which will take place on November 10-12, 2011.

I understand that this trip will be taken by (x) auto ( ) van ( ) boat ( ) bus (check one.) I further understand that an authorized adult will be in charge at all times and will take necessary measures to the best of his or her ability for the protection of health and safety of the group.

X \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent or Guardian Date

\_\_\_\_\_  
Address ( ) \_\_\_\_\_  
PHONE

EMAIL : \_\_\_\_\_ ( ) \_\_\_\_\_  
CELL

**In case of emergency notify:**

\_\_\_\_\_  
Please Print Name ( ) \_\_\_\_\_  
PHONE

\_\_\_\_\_  
Address

Special Medical Conditions of Minor, such as DIABETES, ALLERGIES, etc. \_\_\_\_\_

Medication Currently Using: \_\_\_\_\_

**Insurance Info:**

Insurance Company Name \_\_\_\_\_ Policy # \_\_\_\_\_

Doctor's Name \_\_\_\_\_ ( ) \_\_\_\_\_  
Please Print Name Phone

**MAKE CHECKS TO LAS FLORES CHURCH, OR PAY ONLINE**

**www.ROOTEDYOUTH.com**