**Permission to Participate**

**Salisbury Student Ministries**

**GENERAL INFORMATION**

Student Name: Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Grade:

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ & \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DESIRE/PERMISSION TO PARTICPATE**

I, the undersigned, desire to participate, or if the participant is less than 18 years old, I give my permission for the participant, in Salisbury Student Ministries Activities.

**Participant’s Medical and Emergency Information:**

Participant’s medical insurance provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_

Name & # of emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY & MEDICAL AUTHORIZATION:**

The medical information provided on this form is correct to the best of my knowledge. I certify that the medical participant is able to participate in all activities unless I have otherwise advised Salisbury Student Ministries Staff in writing. I also certify that all medical conditions or allergies, which may limit the participant’s participation in activities, are listed.

**FOR PARENTS:** In the event I cannot be reached in case of an emergency, I hereby authorize Salisbury Student Ministries, or their respective directors, staff or volunteers to make emergency medical decisions and/or administer emergency medical assistance. I accept responsibility for payment of expenses incurred as a result of any medical treatment.

I have read, agree to, and understand all the terms in this document. The information I have provided on this form is accurate to the best of my knowledge. I agree that all of the terms in this document apply to the Salisbury Student Ministry Activities. The signature below signifies approval of all information and terms in this document.

**PARTICPANT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT/GUARDIAN SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**