



TRIP APPLICATION/PARENT CONSENT AND RELEASE FORM

First Christian Church
115 Courthouse Plaza
Manhattan, KS 66502
785-776-8790

Emergency Contact Name _____ Phone # _____ - _____ - _____

Child's Name _____ Age _____ Date of Birth _____

Current grade or grade just completed _____ School _____

Home Mailing Address _____

City _____ State _____ Zip _____

Parent/Guardian Name _____ Phone _____

To whom it may concern:

The undersigned does hereby give permission to our (my) child, _____, to attend and participate in the overall activities sponsored by Manhattan First Christian Church (Disciples of Christ) from **August 1st, 2011 to July 31st, 2012**. We (I) authorize the group leader, in whose care the minor has been entrusted, to consent to any X-Ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff or a licensed hospital, whether diagnosis or treatment is rendered at the office of a physician or at said hospital. The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization. Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by First Christian Church.

Parent/Guardian Signature _____ Date _____

Hospital Insurance? Yes No (circle one)

Participant's Signature _____

or

Insurance Company _____

Parent Signature _____

or

Policy Number _____

Legal Guardian's Signature _____

Physician _____

Date of last Tetanus Shot _____

Physician Phone _____

Please list any allergies or special medical needs for your child. Thanks! _____
