Annual Permission Slip

September 2025 through August 2026

EPIC Student Ministry of SonRise Church

I, _____, give permission for my
(Parent/Guardian)

son(s) and/or daughter(s) _____, to
(List each Student's Name)

participate in **all** EPIC Student Ministry associated events. This includes all activities both at SonRise Church and off-site; this also includes travel. This permission slip is good and in effect from September 1, 2025, through August 31, 2026.

If a problem arises that requires my child(ren) to need to return home prior to the end of an activity, I will pay for his/her return home or pick my child(ren) up.

Release of Liability

I/We, the parent(s) or legal guardian(s) of the above participant(s) do hereby release SonRise Church, EPIC Student Ministry, the church staff, all sponsors, and volunteers from any and all liability resulting from any physical injury, property damages or loss, or other injury or damage which occurs during an event. I/We accept personal financial responsibility for any bodily or personal injury or loss sustained during the activity. The participant(s) and/or parent(s)/guardians(s) agrees to indemnify and hold harmless EPIC Student Ministry and SonRise Church for any such loss, injury or expense.

Medical Treatment

_____, has the permission of the
(List each Student's Name)

undersigned to participate in EPIC Student Ministry of SonRise Church activities. In the event of an emergency affecting the health or welfare of this/these participant(s), the sponsors, leaders, volunteers, staff, or chaperones have permission to administer first aid and/or transport the individual(s) to the nearest doctor or hospital for further medical attention, as deemed necessary. The individual action in response to the emergency will be held blameless. And medical expenses occurring will be borne by the parents or guardians of the participant(s).

Media Permission

I/We give permission to EPIC Student Ministry of SonRise Church, and SonRise Church to use any media coverage of my child(ren) including photographs and videos of an activity in our publicity materials such as our Facebook page, church website, and future promotions.

Name of Student(s)	Date of birth	Grade in fall of 2025
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address:_____

Home Phone:_____

Parent/Legal Guardian:_____

Relationship:_____ Work Number:_____

Cell:_____ Email:_____

Parent/Legal Guardian:_____

Relationship:_____ Work Number:_____

Cell:_____ Email:_____

Emergency Contact:_____ Phone:_____

Current Medications: My child(ren) is (are) taking the below listed medications and will bring all needed medications, which will be well labeled. My child(ren) will administer his/her own medication. If there is more than 1 participant please give their name along with their medications.

_____

_____

_____

Please list any known allergies per participant by first listing their name along with the known allergies:

Does your child/ren have any physical limitations or medically prescribed dietary needs? If there is more than 1 participant please give their name along with any physical limitations or medically prescribed dietary needs.

If you need more space for special situations such as a child who has a differing address from the other students, i.e. a stepchild, or need more space than provided, please feel free to attach another sheet of paper or use the back of the last page.

Name of Insured:_____ Insurance Company:_____

Group Number:_____ Policy Number:_____

Signature of Parent/Guardian:_____ Date:_____

Name of Parent/Guardian:_____

Nonprescription Medicine Permission

By signing below you are agreeing to hereby grant permission for nonprescription

medication (such as ibuprofen, Tylenol, cough syrup, etc.) to be given to your child(ren) if deemed advisable.

Signature of Parent/Guardian:_____ Date:_____

Name of Parent/Guardian:_____

Authorization of Medical Treatment

By signing below, I/We, the parent(s)/guardian(s), grant permission to the hospital/medical facility(ies) to administer any medical treatments deemed necessary to my child(ren). Without this signature, the hospital/medical facility may decide to delay or not treat your child(ren) until they can contact you, the parent(s)/guardian(s), and obtain permission.

Signature of Parent/Guardian:_____ Date:_____

Name of Parent/Guardian:_____