Event: General Youth Events

Date: August 20, 2023 - August 20, 2024

Participant's Name _____

Street Address _____

City, State, Zip _____

Current Grade _____ Date of Birth _____

I hereby grant permission for my child, named above, to participate in all yearly activities with the Covenant Community Church Student Ministries program. I understand that my child participates in these activities at his or her own risk, and I hereby waive and release the Covenant Community Church, its Student Ministries Directors, and its volunteer adult supervisors from all liability for any injury, personal or otherwise, to my child or caused by my child during the course of his or her participation in these activities, including during transportation to and from the activity location, if applicable. Should any problems arise concerning the behavior of my child that would require that he or she return home prior to the end of any activity, I agree to be held responsible for any related transportation costs. Furthermore, I recognize that Covenant Community Church and its Student Ministries program uses photographs and video images of events in published materials such as the Church website, newsletters and bulletins, and I hereby grant permission for photo/video images of my child to be taken and to be used for such purposes.

In the event of a medical emergency, I hereby authorize the treatment of my child, the minor named above, by a qualified and licensed medical doctor if it is the opinion of that doctor that the treatment is medically necessary and I cannot be reached after reasonable effort has been made to secure my personal consent. Further, I agree to be held responsible for any medical expenses that may be incurred as a result.

Signed: _____ Date: _____

(Parent or legal guardian)

Home Phone: (____)____-_____ Work Phone: (____)___-_____ Cell Phone: (____)___-_____

Covenant Community Church
2250 S. Yukon Parkway
Yukon, OK 73099
(405) 354-9338

Participant Details

Participant Name: _____

Emergency Contacts:

1. Name: _____Relationship to Participant _____

Day Phone (_____)____-_____ Night Phone (_____)____-_____

2. Name: _____Relationship to Participant _____

Day Phone (_____)____-_____ Night Phone (_____)____-_____

Medical Insurance Co. _____ Phone (____)____-_____

Policy and/or Plan #: _____

Primary Care Physician: _____

Address: _____

City _____ State ____Zip _____ Telephone Number (_____)____-_____

Special Medical Conditions—(Allergies, chronic illness, special needs, or other conditions:

_____

_____

_____

Current Medications:

_____

_____

_____

I certify that, to the best of my knowledge, the above information is accurate and current as of the date below.

Signed: _____ Date: _____

(Parent or legal guardian)