TRAIL CHRISTIAN FELLOWSHIP
MEDICAL AND PERMISSION SLIP

This form must be completed and returned to the TCF Leader before you may participate in this event.

Name(s) of Attendee(s):_____

Birthdate(s):_____

Address:_____

Email:_____

Primary Phone: _____ Texting: Y N

Health Insurance: Y N Provider:_____

I hereby give permission for the above listed to attend and participate in Trail Christian

Fellowship's event: _____.
(Name of event) (Date)

_____: PERMISSION TO TREAT ABOVE LISTED (EVEN A MINOR)
(Initial to allow) I authorize Trail Christian Fellowship, in whose care the above listed has been entrusted, to consent to any emergency transportation, 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 of a licensed hospital or emergency care facility. The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and/or dental services rendered to the aforementioned to this authorization.

_____: PHOTOGRAPH RELEASE
(Initial to allow) I hereby grant permission to Trail Christian Fellowship to use photographic images containing the face and likeness of above listed for various purposes such as printed material, publications, displays, video productions, Pro Presenter presentations, etc., as well as for the various TCF sites on the World Wide Web (WWW). I also acknowledge TCF's right to crop or treat the photographic image at its discretion.

_____
(Legal Responsible Party Signature) (Phone) (Date)

Please list any info (medication, allergies, known medical conditions, etc.) that we need to know to better

look after the attendee(s):_____

_____

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