FIRST UNITARIAN UNIVERALIST CHURCH OF DETROIT
BRIDGES PROGRAM FOR YOUTH

Parent Permission For Church Sponsored Activity
And Consent to Medical Treatment

Please complete both top and bottom of form

(Name of Student)_____ has the opportunity to participate in an activity as a part of the Bridges Youth Program. This activity will include being driven in a private vehicle by a church member or staff person. This activity could involve sports or other physical activities.

I understand that my son/daughter will be participating and that he/she is expected to abide by all church regulations during the course of the activity. If my child does not exhibit proper behavior, they may be asked to leave the activity and/or I may be asked to pick them up.

I hereby give my permission for him/her to participate in the Bridges Youth Program and related activities. I give permission for my child to be driven to/from activities and to/from the church and my residence or the child's school by church staff or adult leaders.

I further agree that, in the event of an accident, illness or any other circumstance requiring medical treatment, such treatment may be procured for my son/daughter without financial obligation to First Unitarian Univeralist Church of Detroit.

Date: _____ Signature of Parent/Guardian _____

IMPORTANT MEDICAL INFORMATION THE YOUTH LEADERS SHOULD KNOW:
_____

EMERGENCY TELEPHONE NUMBERS: _____

THIS FORM SHOULD BE KEPT BY THE CHAPERONE DURING THE ACTIVITY
(Please complete the form below)

AUTHORIZATION TO TREAT A MINOR

I (We), the undersigned parent, parents or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by an is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Michigan. It is understood that effort shall be made to contact the undersigned prior to rending treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Date:_____ Signature of _____
Father and/or Mother, or Guardian

Allergies to Drugs or Foods _____

Date of last Tetanus Booster _____

PLEASE COMPLETE BOTH TOP AND BOTTOM OF FORM