

Waypoint Community Church/AMP Student Ministries

332 58th, Springfield, Oregon 97478

Phone: 541-288-1267

**PARENT/GUARDIAN PERMISSION Ignite Conference November 10-14,
2016**

I, (print your name) _____,
give permission for my son/daughter, (print child(ren)'s name) below:

_____, _____,

_____ to participate in the AMP Student Ministries trip/activity. I understand that as in any youth ministries activity, my child(ren) may encounter risks to his/her health and safety. Emergency care for my child may be provided and authorized by another adult volunteer without the presence of youth leaders during this activity. Recognizing this, I give permission for my child(ren) to participate in the Ignite Conference trip on November 10-14, 2016. I release the Pastors of Waypoint Community Church, its staff, all of its Board, its officers and directors, and all other persons involved in Waypoint Community Church/AMP Student Ministries (including the AMP Student Ministries volunteers) from any liability arising out of any accident, injury, or sickness that may happen to my child(ren). I will instruct my child(ren) to obey rules of the trip/activity, and I understand that if my child disobeys those rules, the AMP leadership team may refuse to allow him/her to continue in the activity.

I understand that photographs and video may be taken of my child(ren) during this event and I release them to be used for future AMP Student Ministries publications.

In the event of a medical emergency, a legal guardian will be contacted. If the legal guardian is unable to be reached, I give permission for the provision of emergency medical care to my child(ren), including blood transfusion and anesthesia, should that, in the sole judgment of those administering such care, be necessary; and I release those persons administering such care from any liability arising from providing the assistance. I agree to accept all financial responsibility for the health care and emergency decisions deemed necessary.

Parent or Guardian's Signature

Date

Print Name: _____

Address: _____ Zip _____

Home Phone #: _____ Work Phone: _____ Cell Phone: _____

Your child's participation will depend upon receipt of this release form prior to the actual event. Thank you for your help!

Please complete the backside of this form.

Child(ren's) date of Birth:

Medical Insurance Carrier: _____

Policy # _____

Policy Holder's Name: _____

I.D. # _____

Student's Physician: _____

Phone# _____

Student's Dentist: _____

Phone# _____

List any prescription medicines your child takes:

Drug name:	Dosage amount:	Timing:	Reason:
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Does your child have any medical conditions that we should be aware of? Provide a list of any handicaps, restrictions or other information about your child
