Grace Community Church
Effect Student Ministries

36015 Friday St. ♦ Richmond, MI 48062 (586) 727-8755

Parental Permission Slip for Youth Group Activities ***2018***

Student Information

Name: First _____ M.I. _____ Last _____

Preferred Name _____ Gender: M or F Birthday __ / __ / _____

Entering ___Grade Fall of _____ School Name: _____

*I hereby agree and consent to my child's participation in the various Grace Community Church Student Ministries activities, scheduled and unscheduled, of the **Grace Community Church** (GCC) of Richmond, and give my permission to GCC, its agents and employees, to exercise such discretion as it/they deem necessary to supervise any and all church-related activities in which my child is a participant for the duration of my child's involvement in the GCC youth department and to exercise its/their discretion in assessing the medical needs of my child and to give permission for and to incur such medical attention, advice, procedures and or expenses as it/they deem necessary and further, I agree not to hold GCC, its agents or employees, responsible for any church related activities, medical care rendered or not rendered, expenses incurred, or the results thereof. I understand that it is my responsibility to inform GCC of any changes pertinent to this form (change in insurance carrier, additional medical information, etc.) and to complete an updated form to keep information on my child current.*

Signature of Father: _____ Date ___/___/2018

Signature of Mother: _____ Date ___/___/2018

Signature of Guardian: _____ Date ___/___/2018

Primary Guardian Information (Parent, Grandparent, etc.)

Name(s): _____ Relationship _____

Address: _____ City: _____ State: ___ Zip: _____

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

Employer: _____

Alternate Emergency Contact

Name: _____ Relationship _____

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

Medical and Insurance Information

Insurance Carrier: _____ Policy #: _____

Child's Doctor: _____ Doctor's Phone #: (___)_____

Known Allergies: _____

Other Pertinent Medical Information: _____

Prescribed Medications: _____

Please attach a copy of both sides of your insurance card