



# Website - **MEDICAL PERMISSION SLIP**

**Child Evangelism Fellowship® of Nebraska Inc.**

P.O. Box 488 • Burwell, NE 68823

308/346-5734 • [cefne@cornhusker.net](mailto:cefne@cornhusker.net) • cell 308/214-0121

This form is valid for all Child Evangelism Fellowship functions for the **year of 20**\_\_\_\_. **It must be completed in full, signed and NOTORIZED.** If the person is under age 19, the parent/guardian must sign below.

Student's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Birth Date \_\_\_/\_\_\_/\_\_\_ \*Age \_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
\*For those under 19 years old.

Social Security Number \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail \_\_\_\_\_

## Medical Information

Please provide any medical information that would help.

Allergies \_\_\_\_\_

Medication(s) taken \_\_\_\_\_

Physical limitations \_\_\_\_\_

Any other medical condition we should be aware of, such as asthma, epilepsy, etc. \_\_\_\_\_

**Medical Insurance Company** \_\_\_\_\_

Policy Holders Name \_\_\_\_\_ Policy # \_\_\_\_\_

Parent's Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Student's Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

### EMERGENCY PHONE NUMBERS

Parent/Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cel \_\_\_\_\_

Other person to contact \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

### Medical Release Form

I give permission for \_\_\_\_\_ to participate in CEF's activities during the **year of 20**\_\_\_\_.

I hereby release CEF, its staff and sponsors from responsibility and liability for any illness or injury the above-named person may sustain during activity. In the event of an emergency, I hereby authorize an adult leader of the activity, as an agent for me, to consent to any X-ray, examination, medical, dental, anesthetic or surgical diagnosis; treatment; and hospital care advised and supervised by a licensed physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are to be rendered, either at the physician's office or in a hospital. I understand the activity director will endeavor to reach us should the nature of the injury or illness warrant it. However, we will not hold any activity personnel responsible if efforts to contact me (us) are unsuccessful.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature and stamp of notary required if student is under age 18 \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Exp. Date \_\_\_\_\_  
Place Stamp here ➔