



Medical Permission Slip
Child Evangelism Fellowship® of Nebraska Inc.
 P.O. Box 488 • Burwell, NE 68823
 308/346-5734 • cell 308/214-0121
 cefne@cornhusker.net

Emergency Numbers at CYIA '10 Central Express Care Clinic • 2525 Pine Lake Road
 Lincoln, NE 68512 • (402) 420-2094 (pharmacy)
BryanLGH East • 1600 S. 48th Street, Lincoln, NE
 68506-1299 • General Info. 402-489-0200

This form is valid for all Child Evangelism Fellowship functions from **January 1, 20__ to December 31, 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 (____) _____ E-mail _____

Social Security Number *For those under 19 years old. _____ Cell phone _____

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 _____ Cell _____

Other person to contact _____ Home Phone _____ Work _____ Cell _____

Medical Release

I give permission for _____ to participate in CEF's activities from Jan. 1, 20__ to Dec. 31, 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.

State of _____)
) ss
 County of _____)

 Signature of parent/guardian
 The foregoing instrument was acknowledged before me this ____ day of _____, 20__ by _____
 (Printed Name of Parent/Guardian)

(Seal)

 (Signature of Notary Public)