

Printed Name

## **ONE YEAR PERMISSION SLIP**

## **Parent Consent / Medical Release Form**

June 1, 2017 to June 1, 2018

BIBLE CHURCH				
1300 South Maple Road Ann Arbor, MI 48103 734-663-0589	Student Name			
	Birthdate	2017-2018 School and Grade		
Address		City	State	Zip
Home Phone	Student Cell Phone	Student Email		
Father's email		Mother's Email		
Name of Hospitaliz Does your child u proper use:	ration Insurance use prescription medication? If s	Policy/Subscriber Nur so, please list the exact me		e instructions for its
Does your child h	nave any special instructions, di	et, allergies, or health cond	litions of which we sh	ould be aware?
Ministries of Grace 1. We (I) author medical, sur supervision medical staf the said hos 2. We (I) also g ministry lead 3. We (I) will n	ve(s) permission for our (my) child bible Church. While our (my) child orize an adult, in whose care the migical or dental diagnosis or treatmend on the advice of any physician of a licensed hospital, whether such pital. give permission for our (my) child to dership staff while attending and part of hold Grace Bible Church or any curred in the treatment thereof.	is participating in approved ac nor has been entrusted, to cor int; or hospital care to be rend and/or dentist licensed under ch diagnosis or treatment is re oride in any vehicle driven by a articipating in an activity spons	tivities:  Insent to any x-ray examinered to the minor under  Ithe provision of the Median at the office of the minor authorized adult apponents.	nation; anesthetic; the general or special dical Practice Act on the he said physician or at binted by the student
<b>Authorized Signa</b>	arrea in the treatment thereor.			
Father (or Legal Gu	ture(s):			
_	ture(s): ardian):	ignature	Cell Phone No	umber

Relationship to Child

Phone Number