

**St. Barnabas Lutheran Church Off-Site Church Activity  
Parental/Guardian Authorization**

Thank you for your interest in having your child participate in an off-site program through our church. This authorization and the procedures the church has developed are intended to provide a safe and secure environment for your youth. Information requested on this application will be confidential and securely stored in the church.

Event \_\_\_\_\_ Destination \_\_\_\_\_

Departure Date/Time/Place \_\_\_\_\_ Return Date/Time/Place \_\_\_\_\_

Cost \$ \_\_\_\_\_ Other Details \_\_\_\_\_

Event Coordinator \_\_\_\_\_ Cell # \_\_\_\_\_

***Please complete & return form below for each participant. Any payment should be to St. Barnabas Lutheran***

\*\*\*\*\*

**IMPORTANT: Deadline for return of form is \_\_\_\_\_**

Participant name \_\_\_\_\_ Date of birth \_\_\_\_\_  
MM/DD/YYYY

Member of St. Barnabas? (circle) YES NO

Address \_\_\_\_\_ Phone \_\_\_\_\_  
(STREET) (CITY) (ZIP)

In consideration of the opportunity for my child to participate in the above activity, and fully recognizing that such an event involves an element of risk, I assume all risks and hazards incidental to such participation, and do hereby release, absolve, indemnify, and agree to hold harmless St. Barnabas Lutheran Church of Cary, IL, its employees and officers, chaperones, leaders, organizers, sponsor, and persons transporting youth to and from this event. Neither St. Barnabas Lutheran Church of Cary, IL, nor any of the said persons above shall be held financially responsible for any injury, illness, or death incurred as a direct or indirect result of this event.

I have read this release, understand all of its terms, and execute it voluntarily and with full knowledge of its significance. In the event of an emergency, if I cannot be contacted, I hereby authorize that emergency medical treatment may be administered.

Parent/Legal Guardian Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address (if different than above) \_\_\_\_\_  
(STREET) (CITY)

If I can't be reached, CALL:

Name: \_\_\_\_\_ Relationship to Participant \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Participant \_\_\_\_\_ Phone \_\_\_\_\_

Please list any food or medication allergies and/or medications the participant is currently taking:

\_\_\_\_\_

Name of Participant's Physician \_\_\_\_\_ PHONE(\_\_\_\_) \_\_\_\_\_

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