

**TRAVEL AND TREATMENT RELEASE**  
**FIRST ASSEMBLY OF GOD, GASTONIA**

As Parent(s)/Guardian(s), I give my permission for

\_\_\_\_\_  
NAME OF CHILD(REN)

to travel with FIRST ASSEMBLY OF GOD, GASTONIA, NC to and from  
the event : \_\_\_\_\_ and to participate in activities  
related to this trip/event.

My signature below attests that I assume responsibility for any liability related to  
damages or injury sustained as a result of my child(ren)'s disobedience. I  
endorse the authority of FIRST ASSEMBLY OF GOD and its operatives as the  
chaperons of my child(ren) for this event, including disciplinary decisions made  
by said operatives during the trip. I understand this may include my child(ren)  
being returned from an event at my expense. ANY RESTRICTIONS,  
COMMENTS:

**AUTHORIZATION FOR TREATMENT**

I, the undersigned parent(s) or guardian(s) of my minor child(ren)

\_\_\_\_\_  
PLEASE WRITE NAME(S) AND AGE(S) HERE

do hereby authorize adult workers with FIRST ASSEMBLY OF GOD, Gastonia,  
NC, as my acting agents, to consent to the following: an examination, medical or  
surgical diagnosis, treatment and/or hospital care. This consent is given  
provided that the treatment or diagnosis is rendered under supervision of any  
physician or surgeon licensed under the provisions of the Medical Practice Act.  
LIST ANY RESTRICTIONS, COMMENTS, OR MEDICATIONS CURRENTLY IN  
USE BY CHILD(REN)\_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN\_\_\_\_\_

DATE\_\_\_\_\_ TELEPHONE\_\_\_\_\_

EMERGENCY CONTACT NUMBER (if different from above)\_\_\_\_\_

PLEASE BE SURE TO **SUPPLY INFORMATION ON BACK**

**PERSONAL DATA SHEET**  
PLEASE COMPLETE AS FULLY AS POSSIBLE

CHILD'S FULL NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_ GENDER: M F BIRTHDATE \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_

BLOOD TYPE \_\_\_\_\_

PLEASE LIST ANY KNOWN ALLERGIES OR REACTIONS \_\_\_\_\_

\_\_\_\_\_

PLEASE LIST ANY PHYSICAL OR MENTAL IMPAIRMENTS, LIMITATIONS, OR PROBLEMS \_\_\_\_\_

\_\_\_\_\_

YOUR INSURANCE COMPANY \_\_\_\_\_

POLICY OR AUTHORIZATION # \_\_\_\_\_