

**Event: GET REAL, Helena April 12-13, 2024**  
**Permission Form Valid Date: April 12-13, 2024**

Student Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ T-Shirt Size \_\_\_\_\_

Parent(s) Names: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Other Phone #: \_\_\_\_\_

Home Church/Youth Group: \_\_\_\_\_

**Medical Release Information**

Medical Allergies: \_\_\_\_\_ Food Allergies: \_\_\_\_\_

Communicable Disease? \_\_\_\_\_ Taking medication? (If yes, please list): \_\_\_\_\_

Known medical conditions: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Permission to treat:

I, \_\_\_\_\_ (parent name, please print), parent/legal guardian of \_\_\_\_\_ (student), give consent to treatment, in case of emergency, at the nearest medical facility. I have given all relevant medical information on this form to aid the medical staff. I understand that I will be contacted at the first possible opportunity, should any medical attention be necessary. I agree to hold MTSBC, Big Sky Fellowship, and chaperones free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I also acknowledge that I will ultimately be responsible for the cost of any medical care. I also understand my student may appear in group photos & videos that may be used for future promotional use.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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