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) N	lames:					
Address:				City/State	e/Zip:	
Primary Phone #: _			Othe	er Phone #:		
		p:				
Medical Release Information		_				
Medical Allergies: Communicable Disease?		F	ood Aller	gies:		
Communicable Disease?	I akin	g medicatio	on? (If yes	s, please list):		
Known medical conditions: Insurance Carrier:		<u> </u>				
Insurance Carrier:	P0	licy #:				
Physician:		Phone:				
Permission to treat:	(noront nome		int) nora	ot/logal guardian of		(atudaat)
I, give consent to treatment, in ca						
this form to aid the medical staf be necessary. I agree to hold N for damages arising from the gi medical care. I also understand	f. I understand th MTSBC, Big Sky I ving of such cons	nat I will be Fellowship, sent. I also	contacted and chap acknowle	d at the first possible berones free and harr edge that I will ultimat	opportunity, sho nless of any cla ely be responsit	uld any medical attention ims, demands, or suits ble for the cost of any
Parent Signature:			Date:			
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	Birthdate:			T-Shirt Size_		
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Address:				City/State	/Zip:	
Primary Phone #:			Othe	er Phone #:		
Home Chu	rch/Youth Group	p:				
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Medical Allergies: Communicable Disease?		Fc	ood Allerg	jies:		
Communicable Disease?	Takinę	y medicatio	n? (If yes	, please list):		
Known medical conditions:						
Insurance Carrier:	Pol	icy #:				
Physician:		Phone:				
Permission to treat:			0			
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notical care. Taiso understanu	my student may	appear in (group pric	tios a videos triat illa		

Parent Signature:_____ Date: _____