8th grade FUN NIGHT!

When: Friday, November 3, 2017
6:30 – 11:00 p.m.
Who: For 8th graders and ONE friend
Cost: **$5 *due A.S.A.P.***
Where: Trinity Lutheran Church – Lindstrom

There will be games, Grog, pizza, Bible study, worship and more.

Please bring: *SNACKS* to share and lots of crazy energy! ***NO ENERGY DRINKS or CELL PHONES.***

Please return this slip *by Wednesday, November 1* (651-257-5129, x23 or linda@trinitylindstrom.org) ***ONLY*** if you are committing to coming. The best plan is to get this into the office a.s.a.p. --- ***because you can't come Friday without it.***

Your FRIENDS also need to turn in a permission slip A.S.A.P.

____ has my permission to participate in the **Senior High Fun Night November 3, 2017 from 6:30 – 11:00 p.m.** at Trinity Lutheran Church in Lindstrom. I recognize that there are risks involved in participating in this activity with Trinity Lutheran Church and hereby assume all risk of injury, harm, or damage to my minor child as they participate in this activity. I hereby release and agree to hold harmless Trinity Lutheran Church and its employees, organizers, and any volunteers assisting in the program, from any and all liability and claims arising out of my child's participation in programs and related activities. I hereby release Trinity Lutheran Church, its staff and sponsors, from responsibility and liability for any injury or illness that my child may sustain during the event.

In case of emergency, where I cannot be reached, I hereby authorize Trinity Lutheran Church to administer necessary first aid or seek emergency medical attention for my child. I hereby authorize an adult leader of this event, as agent for me, to consent to any x-ray examination; medical, dental or surgical diagnosis; treatment; and/or hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at the doctor's office or in any hospital. I expect to be contacted as soon as possible. I understand that I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital care or treatment that is given to my minor child.

I give my permission for my child to be photographed/videotaped. I understand that the images may be displayed in church publications, church building, website and/or social media. I understand that as a precaution, my child's names will NOT be published or linked with photographs.

____ **Date**______________________
SIGNATURE of Parent/Guardian

PARENTS: Would you be willing to help? Yes _______ No ________

EMERGENCY INFORMATION: In case of emergency, please contact (when parent/guardian cannot be reached):

Name____
Phone(s) ____

MEDICAL INFORMATION:

DOCTOR ________________________ Phone______________ or
CIRCLE ONE: C. L. Clinic 651-257-8400 ✦ Fairview-Wyoming 651-982-7000 ✦ St. Croix Clinic 1-800-642-1336

Please list any allergies______________________________
Medications being taken______________________________
Medical/dietary needs______________________________
Physical handicaps or limitations ______________________________
Medical insurance company ______________________Policy#______________
Group # ______________