



AVIATOR STUDENT MINISTRY 2011
Parent Information, Release & Health Form
 Aviator Church, 620 N. Rock Rd. Suite 230-230, Derby, KS 37037
 (COVERED FOR ALL EVENTS IN 2010 CALENDAR YEAR)

Name of Student: _____
 Date of Birth: _____ Sex: _____
 Name of Parent/Guardian(s): _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____
 Student Cell: _____
 Cell Provider (Receive Info via Text): _____
 Parent Cell _____
 Cell Provider (Receive Info via Text): _____
 Parent Work: _____
 Parent Email: _____
 Student's T-shirt Size: S M L XL 2XL

AVIATOR STUDENT RELEASE OF RESPONSIBILITY

- I understand that my child will be attending youth activities, events, trips & retreats with Aviator Church and I am hereby giving my child permission to participate in these activities.
- I understand that all safety precautions will be taken at all times during events in and outside of the church.
- I agree not to hold the church, its staff, or volunteers responsible for injuries or accidents.
- I agree to allow my child's photos to be used on the Aviator Church media including web and print materials.

Parent Signature: _____ Date: _____

AVIATOR STUDENT RULES OF BEHAVIOR EXPECTED FROM STUDENTS

1. Honor God, build relationships & have a blast!
2. Respect other students, all Aviator Student staff and volunteers, and all other authority.
3. No alcohol, drugs or tobacco.
4. No firearms, knives or weapons of any kind.

I understand the Aviator Student rules and guidelines and I plan to obey all of them!

Student Signature: _____ Date: _____

I understand the Aviator Student rules and guidelines and I understand that if my child fails to adhere to them I must pay for transportation for my child to leave the event early.

Parent Signature: _____ Date: _____

AVIATOR STUDENT HEALTH FORM

Name of Student: _____

Social Security Number: _____

Emergency Contact Person: _____

Emergency Contact Phone Number: _____

Alternate Contact Person: _____

Alternate Contact Phone: _____

INSURANCE:

Do you have health insurance? YES _____ NO _____

Name of insurance Company: _____

Policy Number: _____

Group Number: _____

In whose name is the insurance? _____

Family Doctor: _____

Phone Number: _____

HEALTH HISTORY:

Preexisting or Present Medical Conditions:

Name and Dosage of any Current Medications:

Allergies? (animals, insect stings, medication, plants, etc.):

Check all that apply:

_____ Hay Fever _____ Heart Condition _____ Asthma

_____ Diabetes _____ Physical Handicap _____ Frequent Stomach Upsets

_____ Epilepsy _____ Nervous Disorders _____ Depression

Any major illnesses during the past year? YES _____ NO _____

If you checked any of the above options, please give details (i.e. normal treatment, etc.)

Date of last Tetanus Booster: _____

Contact Lenses: YES _____ NO _____

Swimming Restrictions: YES _____ NO _____

What Restrictions? _____

Any Other Activity Restrictions? YES _____ NO _____

What Restrictions? _____