2025 District Powette

Permission Slip (for Girls 3rd-12th grade)

Where: Camp Wilderness (south of Ft. Meade, FL)

When: Friday, March 14th – Sunday, March 16th

Meet: at Greeneway Church
Friday, March 14th at 8 a.m.

Pickup: at Greeneway Church
Sunday, March 16th at 2:30-3 p.m. (possibly earlier)

Cost: $119 Early registration ** DEADLINE Monday Feb, 10th **
$129 Late registration ** AFTER Feb. 10th

Bring: See Packing List

Any Questions: Ms. Tonishah email- girls@greenewaychurch.com
Additional Info: Church Office: 407-240-5442

(Parent keeps top of form)

2025 District Powette
Camp Wilderness (south of Ft. Meade, FL)
Friday, March 14th - Sunday, March 16th

I hereby give my permission for my daughter, _____, to attend the 2025. District Powette with the Greeneway Church Girls Ministries. I authorize medical treatment at my own expense in case of a medical emergency during March 14th– March 16th.

_____ ____/____/2025
Parent or Guardian Signature Date

ATTENTION MEN PLEASE CONSIDER HELPING US SET UP ON CAMPSITE
PLEASE SEE MS. TONISHAH FOR MORE DETAILS

Girls

EMERGENCY MEDICAL AND CONSENT FORM

Name of City:_____
Name of Church:_____

Each attendee must turn in this Emergency Medical Release form before she will be permitted to participate in District Girls Ministries event activities. Please turn in upon arrival, and pick up before departure for home.

DO NOT SEND TO DISTRICT OFFICE

Student Name: _____ Date of Birth:____/____/_____
Home Address: _____ City:_____ State: ___Zip:_____

Parent/Guardian Name:_____ Parent/Guardian Phone:(_____) _____ -_____

If Parent/Guardian can not be contacted, please provide an additional emergency contact
Name: _____ Phone:(_____) _____ -_____
Relationship to Student: _____

Insurance Carrier: _____ Insurance Phone:(_____) _____ -_____
Insurance Policy and/or Group Number_____
Policy Holder Name: _____ Coverage start:_____Coverage End: _____

CHRONIC/RECURRING CONDITIONS: (Please check any that apply)
__ Seizure Disorders __ Diabetes __ Fainting__ Headaches__ Heart Disease __ Kidney Disease
__ Nosebleeds __Asthma / Respiratory problems__ Sleepwalking __ Other:_____

IMMUNIZATIONS: Are school shot records current? (circle one) YES NO

ALLERGIES: Does your child have allergies:(circle one) YES NO
If Yes please explain:_____

MEDICATIONS: Please list any current medications:_____

Do we have permission to give student, tylenol, benadryl, ibuprofen as needed? (Circle one) YES NO

OTHER:Is there anything else we should know?:_____

AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF PENINSULAR DISTRICT COUNCIL OF THE ASSEMBLIES OF GOD USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM PEN FLORIDA GIRLS MINISTRIES IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND PENINSULAR DISTRICT COUNCIL OF THE ASSEMBLIES OF GOD HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

Parent/Guardian Statement: I authorize the adult in charge to consent to medical treatment if I cannot be contacted. I understand that every effort will be made to contact me before such action is taken. I assume financial responsibility for emergency care if such care is not covered by church's insurance.

SIGN HERE: _____ _____ _____

Parent/Guardian Signature | Parent/Guardian Name (Print) | Date

Name of City:_____
Name of Church:_____

Adult

EMERGENCY MEDICAL AND CONSENT FORM

Each attendee must turn in this Emergency Medical Release form before she will be permitted to participate in District Girls Ministries event activities. Please turn in upon arrival, and pick up before departure for home.

DO NOT SEND TO DISTRICT OFFICE

Name: _____ Date of Birth:____/____/_____
Home Address: _____ City:_____ State: ___Zip:_____

In case of Emergency, Please notify
Name: _____ Phone:(_____) _____ -_____
Relationship: _____

Insurance Carrier: _____ Insurance Phone:(_____) _____ -_____
Insurance Policy and/or Group Number_____
Policy Holder Name: _____ Coverage start:_____Coverage End: _____

CHRONIC/RECURRING CONDITIONS: (Please check any that apply)
__ Seizure Disorders __ Diabetes __ Fainting__ Headaches__ Heart Disease __ Kidney Disease
__ Nosebleeds __ Asthma / Respiratory problems__ Sleepwalking __ Other:_____

IMMUNIZATIONS: (Last date given) _____ Tetanus Shot

ALLERGIES: Do you have allergies:(circle one) YES NO
If Yes please explain:_____

Current Medications:_____

OTHER:Is there anything else we should know?:_____

SIGN HERE: _____ _____ _____
Signature Print) Date