

Parental Consent Form

Child _____ Age _____ Birthdate _____

Address, _____

City, State, Zip _____

Home Phone _____ Grade just completed _____

Father _____ Work Phone _____

Cell Phone _____

Mother _____ Work Phone _____

Cell Phone _____

Emergency Contact _____ Phone _____

We/I hereby give permission for my child to participate in all activities sponsored by Faith Christian Church.

We/I hereby give permission for our/my child to ride in any vehicle designated by the adult(s) in whose care my child has been entrusted while attending and participating in activities sponsored by Faith Christian Church.

We/I give permission for any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to our/my child by any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

We/I agree to pay any and all costs and expenses incurred in connection with such medical and dental services rendered.

We/I will not hold Faith Christian Church, its staff, leadership or volunteers liable in case of an accident, injury, or harm to our/my child. Further, we/I waive any and all right to any claim or cause of action against the aforesated parties which may arise as a result of accident, injury, or other occurrence to our/my child during any activity sponsored by Faith Christian Church and agree to hold Faith Christian Church, its staff, leadership or volunteers absolutely harmless.

We/I agree to all of the terms listed above. Please sign below.

Father

Date

Mother

Date

(please see other side)

Medical Release Form

Health Record

Drug Allergies Yes___ No ___ If Yes, please list _____

Food Allergies Yes___ No ___ If Yes, please list _____

Bee Sting Allergy Yes___ No___ If Yes, course of action in case of sting _____

Other Allergies Yes___ No___ If Yes, please list _____

Does your child have any medical conditions we need to be aware of? _____

Please list all medications presently being taken, dosage amount, and the time of day to be administered while your child is in our care _____

Last Tetanus Booster _____

Primary Insurance Coverage is your responsibility.

Health Insurance Co. _____ Phone (____) _____

Policy or Group Number _____

Family Physician _____ City _____ Phone (____) _____

Dentist _____ City _____ Phone (____) _____