Immanuel Baptist Church Youth Ministries 20010-11 Permission, Health and Liability Release Form

Child's name:

Address:

City, State, Zip:

Phone:

Date of Birth:

Mom's Name: _____

Dad's Name: _____

Mom's Phone:

(H) _____

(W) _____

(Cell) _____

Dad's Phone:

(H) _____

(W) _____

(Cell) _____

Child's Cell Phone _____

Do Staff and Adult Volunteer's of Immanuel Baptist Church Jr/Sr High Ministries have permission to contact your child on their cell phone?

☐ **Yes**

☐ **Yes, but only pastoral staff**

☐ **Yes, but only the following adult volunteers**

_____

_____

☐ **No One Can Contact My Child on their cell phone**

Family Doctor:

Name: _____ **Phone:**

_____

Insurance Company Name:

_____ **Phone:**

_____ **Policy #:**

_____ **Group #:**

_____

1. Is your child presently being treated for an injury or sickness, taking any medication or carrying any emergency medication? **YES** **NO**

Medication _____

Dose _____

Taken for? _____

2. Is your child allergic to any type of medication?
YES **NO**

3. Does your child require a special diet?
YES **NO**

4. Does your child have (or has he/she ever had) any of the following? (circle and explain below)

Seizure disorder	Head injury
Asthma	Seasonal Allergies
Kidney disease	Diabetes
Heart murmur	Heart condition

5. Does your child have any allergies other than medicines?
YES **NO**

6. Does your child sleepwalk? **YES** **NO**

7. Does your child have any physical handicap or illness, which would prevent him/her from participating in normal rigorous activity? **YES** **NO**

8. Please circle one: My child CAN/CANNOT swim

Please explain any "YES" answers from questions 1 through 8:

_____

_____

_____

_____

_____

_____

_____

PARENT/GUARDIAN OF A MINOR: MEDICAL TREATMENT CONSENT

I, the undersigned being the parent or legal guardian of the child named herein ("the child"), do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment which may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leadership to make decisions necessary for the child's treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child. The policy of the church or organization sponsoring this event will be used as the secondary coverage. I additionally agree to notify Immanuel Baptist Church in the event of any health changes which would restrict my child's participation in any youth activities for which this form stands.

_____

Date **Parent/Guardian signature For Above Information/Release**