

FAITH EVANGELICAL FREE CHURCH

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

PARENTAL CONSENT FOR PARTICIPATION IN ALL YOUTH DEPARTMENT ACTIVITIES

Child's Name (Last, First) _____

Address _____ City _____ State ____ Zip _____

Phone _____ Date of Birth _____ Sex: M ____ F ____

In an emergency notify _____ Phone _____

Family Doctor _____ Phone _____

PHYSICAL CONDITION (Check and specify; if other than good; give details)

- ___ Frequent Colds ___ Allergies- please list _____
___ Asthma ___ Heart condition
___ Diabetes ___ Rheumatic Fever
___ Epilepsy or other nervous system disorder ___ Stomach upsets
___ Eye, ear, nose, throat.

Please inform us as to what medication(s) your son/daughter is taking on a daily basis AND the dosages. _____

Check here if you give your consent for the Youth Staff to administer OTC medications to your son/daughter deemed necessary (i.e. ibuprofen, anti-acid etc.).

Date of last Tetanus shot _____
Date of Polio Vaccine: 1st: _____, 2nd _____, 3rd _____
Any swimming restrictions: Yes ___ No ___
Any activity restrictions: Yes ___ No ___ (give details on back of this form)

To my knowledge, he/she has ____, has not ____ been exposed to contagious infectious disease in the last 3 weeks.

Insurance Company _____ Policy Number _____

I/we _____, the parent (or legal guardian) of the above-named child, hereby give my/our consent to youth participation in the scheduled youth activity. I/we assume all risks and hazards incidental to such participation, including transportation to and from the activity, and I/we hereby waive, release, absolve, indemnify and agree to hold harmless Faith Evangelical Free Church sponsors, supervisors, organizers and persons transporting my/our child to or from such activity, for any claims out of an injury to my/our child, except to the extent and in the amount covered by accident or liability insurance.

I/we, the undersigned, parent(s) (or legal guardian) of _____ MINOR, do hereby authorize the youth coordinator/church staff member for the undersigned to consent to any X-ray, anesthetic, medical or surgical diagnosis of treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provision of the State of Pennsylvania, 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.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required and is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. I know of no health reason why my son/daughter may not participate in any Youth Department activities.

Faith Church sometimes uses photographs taken during Youth events for various purposes on our website, in our brochures, etc. If you would prefer us NOT to use your son/daughter's picture, please check this box []

SIGNATURE: _____ Date: _____

Address _____

Home Phone: _____ Cell Phone: _____