



# 2009 - 2010 PARENTAL CONSENT FORM

July 1, 2009 – June 30, 2010 *(Please use ink)*



Child/Youth Name: \_\_\_\_\_ Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Child/Youth E-mail Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Parent's Work Phone: \_\_\_\_\_ Cell Phone(s): \_\_\_\_\_

Parents' Email Addresses: \_\_\_\_\_

**PARTICIPATION CONSENT:** The undersigned does hereby give permission for our (my) child named above to attend and participate in activities sponsored by **Trinity (Boyertown) Evangelical Congregational Church**.

I understand the Trinity E.C. Church and Youth/Children's Group is not responsible or liable for their personal effects and property and that they will not provide lock up or security for any items. I will hold them harmless in the event of theft or for loss resulting from any source or cause. I further understand that they (minor) are to abide by whatever rules and regulations may be in effect for the accommodations at that time.

By my signature, for myself, my estate and my heirs, I release, discharge, indemnify, and forever hold harmless Trinity E.C. Church, Children's/Youth, and any related agency, conference, church leader, member, employee or agent of Trinity E. C. Church, from any liability, injury, damages, loss, accident, delay or irregularity related to the undersigned individual planned or participation or involvement in these or this activity.

**MEDICAL CONSENT:** We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of 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. The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical or dental services rendered for the aforementioned child pursuant to his authorization.

**TRANSPORTATION CONSENT:** The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by **Trinity (Boyertown) Evangelical Congregational Church**. Should it be necessary for our (my) child to return home due to medical reasons or improper behavior, the undersigned shall assume all transportation costs and responsibilities.

**PROMOTIONAL CONSENT:** The undersigned does also hereby give permission for any photos of our (my) child to be used in promotional materials and/or in the Trinity's Children/Youth Ministries promotion, and web page understanding that no names or personal information will be used.

Hospital Insurance: Yes ( ) No ( )

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Emergency Phone Numbers: \_\_\_\_\_

\_\_\_\_\_  
Child/Youth Signature (required!) Date

\_\_\_\_\_  
Father Signature Date

\_\_\_\_\_  
Mother Signature Date

\_\_\_\_\_  
Legal Guardian Signature Date

**\* Please make a photocopy of the front and back of your insurance card for our records. \***



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### PLEASE PRINT

Child/Youth Name: \_\_\_\_\_ Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Grade: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Vision impairment: \_\_\_\_\_

Blood Type: \_\_\_\_\_ Date of last Tetanus Shot: \_\_\_\_\_

### **PAST OR PRESENT ILLNESSES** (Give approximate dates or mark "N/A" if not applicable):

Ear Infections _____	German Measles _____	Seizures _____
Asthma _____	Mumps _____	Lung _____
Diabetes _____	Kidney _____	Heart _____
Measles _____	Rheumatic Fever _____	Other _____

### **ALLERGIES:**

**MEDICATIONS:** Penicillin \_\_\_\_\_  
Other medications (please list) \_\_\_\_\_

**FOOD(S):** (Please list) \_\_\_\_\_

**MISC:** Hay Fever \_\_\_\_\_ Poisons (Ivy, etc) \_\_\_\_\_ Bee Stings \_\_\_\_\_

List any physical limitations or concerns: \_\_\_\_\_  
\_\_\_\_\_

Please provide other helpful health information: \_\_\_\_\_  
\_\_\_\_\_

**Personal Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dentist/Orthodontist Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### **PARENT'S AUTHORIZATION:**

*The above health history is correct and, in the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the adult(s) in charge of the event to hospitalize, secure proper treatment for and order injection, anesthesia and/or surgery for my child.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_