

Cornerstone Church of the Nazarene
Youth Permission, Medical, and Photo Release Form

I give my child, _____, permission to participate in all Youth Ministry activities, trips, and programs sponsored by Cornerstone Church of the Nazarene in Lake Jackson, Texas.

General Information

Child's name: _____ Birthday: ____/____/____

Address: _____
(Street) (City) (Zip)

School attending: _____ Grade level: _____

Home Phone #: _____ Child's Cell #: _____

Father's name: _____ Cell #: _____

Mother's name: _____ Cell #: _____

I understand that the chaperones will use their best efforts to supervise; however, I also understand they are not responsible for loss of personal property or bodily injury.

Signature of Parent/Guardian Date

During youth events, there will be photos taken for church use on the web site and/or slideshows. Will you give us your permission to use these photos of your child, knowing that your child's name will not be attached to these photos.

I give permission for Cornerstone Church of the Nazarene to use my child's photo:

Signature of Parent/Guardian Date

Medical Information and Emergency Release

In the event my child becomes ill, is injured or requires emergency medical attention of any kind, and I cannot be reached by phone, I authorize the adult chaperone(s) to make the necessary decision concerning emergency treatment. I also give permission for my child to be transported to the nearest medical facility or hospital for treatment. I understand that I will assume full responsibility for the payment of services rendered.

Signature of Parent/Guardian Date

This release is in effect for one year from the date signed.

Medical Information:

If a parent cannot be reached, please contact the emergency person listed below.

Name: _____ Home/Cell #: _____

Relationship: _____

My child wears contacts lenses: YES NO

My child's last Tetanus shot was administered on: _____

My child's allergies to medications are: _____

My child's other allergies are: _____

The medications my child takes on a regular basis are: _____

Other information about my child that should be known to healthcare providers is:

Name of Child's Physician: _____

Physician's Office #: _____

Medical Insurance Company: _____

Phone #: _____

Policy #: _____ Group #: _____