2019 Parental Consent for Medical Treatment

Participant Name _____

(please one form per person)

Birth date (mm/dd/yyyy) _____ Grade _____

School _____

Parent / Guardian Name

_____

Cell _____ Email _____

Address _____

Parent / Guardian Name _____

Cell _____ Email _____

Address _____

Fairmount staff periodically photographs youth activities to highlight for the youth and the congregation the vibrant life of Fairmount Youth Ministry.
If you DO NOT want your child to be included in photography please initial here: _____

Medical Information

Allergies or physical limitations: _____

_____

Medications and dose: _____

Medical Insurance Company: _____

Policy Number _____ Insured member's name _____

Liability Release and Consent for Treatment

I hereby release Fairmount Presbyterian Church, its staff, and adult representatives from responsibility and liability for any injury or illness that my child may sustain during an event. In the event of an emergency, I hereby authorize an adult leader of this activity as an agent for me, to consent to any X-ray examination, medical, dental, or surgical diagnosis; treatment; and hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where services are rendered, either at a doctor's office or in any hospital. I expect to be contacted as soon as possible.

Parent or guardian signature _____ Date _____

Please return this form to the church or by emailing amykim@fpccle.org