



# eYTH ACTIVITIES | 2020 Parental Consent & Medical Treatment Form

Name of Church: **Evergreen Christian Center**

Youth Pastors: **Ilcian & Carlos**

I, the undersigned parent or guardian of \_\_\_\_\_, a minor, do hereby authorize adult workers with the youth of the above named church to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is rendered under the supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act of the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. Further, as parent or guardian of the minor named above, I do hereby expressly consent that my son/daughter may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me and do further agree to hold blameless any physician, hospital or other medical center for rendering such services. I, the undersigned have legal custody of the student named above, a minor, and have given my consent for him/her to attend events being organized by Evergreen Christian Center. I understand that there are inherent risks involved in any ministry or athletic event, and I hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my child's involvement.

Parent or Guardian Initials: \_\_\_\_\_

### PHOTOS

I give Evergreen Christian Center permission to record my child's photograph/video image or voice and grant Evergreen Christian Center all rights to use any such recordings for educational, promotional, advertising, or other non-commercial purposes that support the mission of the Church. I agree that all rights to these recordings belong to Evergreen Christian Center.

Parent or Guardian Initials: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_  
Address: \_\_\_\_\_ [City] \_\_\_\_\_ [Zip] \_\_\_\_\_  
School: \_\_\_\_\_ Gender: [M] or [F] Student's Cell \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact [not parent]: \_\_\_\_\_ Phone: \_\_\_\_\_

Permission is given to dispense over-the counter health medications to my child: Yes  No   
Year of last Tetanus Shot: \_\_\_\_\_ Is your child allergic to any Medication?: Yes  No   
If yes, please list: \_\_\_\_\_

Please describe any allergies, medical problems, recurring illness, or chronic conditions: \_\_\_\_\_

Is your child on any medication (prescription or non-prescription)? Yes  No

If yes, please state the name of the medication: \_\_\_\_\_

Describe any strenuous activities the participant is to be restricted from or other information we should know regarding the health of the participant: \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date