2018-2019

CHILD/STUDENT REGISTRATION & MEDICAL TREATMENT RELEASE FORM

CENTRALongmont PRESBYTERIAN CHURCH
402 Kimbark Street, Longmont, CO 80501 Phone: 303-776-6833

STUDENT INFORMATION

Student Name _____ Emergency Contact _____
Birthdate (mo/day/yr) _____ _____
Grade in the Fall _____ School _____ Email _____
Address _____ Emergency Phone _____
City, Zip _____
Home Phone _____

PARENT #1	PARENT #2
Relationship _____	Relationship _____
Name _____	Name _____
Address _____	Address _____
City, Zip _____	City, Zip _____
Home Phone _____	Home Phone (___) _____
Fax _____	Fax _____
Pager _____	Pager _____
Cellular _____	Cellular _____
E-Mail _____	E-Mail _____
Work Place _____	Work Place _____
Work Phone _____	Work Phone (___) _____

MEDICAL INFORMATION

Insurance Co. _____ Policy # _____
Physician _____ Physician Phone _____

Medical History (Allergies, drug reactions, etc., which may be needed in any treatment)

_____

_____

_____

MEDICAL RELEASE – Signature of at least one parent is required

By filling out and signing this form, you give permission for your child to participate in programs or activities authorized by and carried out under the supervision of the Children's/Youth Ministry of CENTRALongmont Presbyterian Church for the time period of June 1, 2018 to May 31, 2019. You also authorize any emergency medical treatment necessary as a result of participation in the programs or activities. Please verify that the above information is correct.

I, _____ am the parent/guardian of _____.
I give my permission for _____ to participate in Central Presbyterian Children's/Youth Church Ministry programs and activities for the time period of **June 1, 2018 to May 31, 2019** and accept full responsibility for my child's participation. I also authorize and consent to any emergency X-Ray examination, medical diagnosis or treatment that may be necessary, provided it shall be under the general or special supervision and on the advice of our family physician or, if it is not practical to reach our family physician, any nurse, emergency medical technician, or physician licensed to practice medicine.

Parent #1 Signature _____ ***Date*** _____

Parent #2 Signature _____ ***Date*** _____