Child Health Emergency Release and Permission (Appendix E)
(C.H.E.R.P)

Elizabeth Presbyterian Church/325 S Banner St./Elizabeth, CO 80107

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 supervision of the Children's Ministry of Elizabeth Presbyterian Church for the time period listed below. You also authorize any emergency medical treatment necessary as a result of participation in the programs or activities.

I, _____ the parent/guardian of _____

(date of birth) _____ Grade ___ School _____, give permission for my child to participate in the Elizabeth Presbyterian Children's 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, it if is not practical to reach our family physician, any nurse, emergency medical technician, or physician licensed to practice medicine. I release the volunteers and staff of Elizabeth Presbyterian Church from responsibility and liability for any illness, injury, harm or loss, during approved activities. My child has my permission to be transported to and from activities in vehicles driven by approved volunteers and staff members.

Parent/Guardian #1 Information

Name _____

Relationship _____

Home Phone _____ Work _____

Cell Phone _____

Email _____

Address _____

_____

Does child reside with Guardian #1 _____

Parent/Guardian #2 Information

Name _____

Relationship _____

Home Phone _____ Work _____

Cell Phone _____

Email _____

Address_____

_____

Does child reside with Guardian #2 _____

Alternate person to contact if I cannot be reached, relationship to child and their phone:

Name _____ Relationship _____ Cell Phone _____

Child's Medical/Health Insurance Company : _____

Policy # : _____ Group #: _____

Family Physician : _____ Phone # : _____

Additional comments regarding medical history, necessary medications, allergies, penicillin or drug reactions, etc. which may be needed in any treatment:

_____

_____

Signature of Parent or legal guardian _____ Date _____

I give my permission for my child's picture to be taken as a part of the children's ministry activities and to be used in any promotion of EPC children's ministry activities including the website. Initial _____