



## Permission Form

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Effective Dates: \_\_\_\_\_ to \_\_\_\_\_

### Please print in ink

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last, First, Middle M D Y

Year in school \_\_\_\_\_  Male  Female E-mail \_\_\_\_\_@\_\_\_\_\_

Address \_\_\_\_\_  
Street, City, State, ZIP

Phone (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Father's Name \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Physician \_\_\_\_\_ Office (\_\_\_\_) \_\_\_\_\_

Dentist \_\_\_\_\_ Office (\_\_\_\_) \_\_\_\_\_

### Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

### Check the following areas of concern for this student. If necessary, add another page with details:

- For your child's safety and our knowledge, is your student a  
 good swimmer  fair swimmer  non-swimmer
- Does your child have allergies to  
 pollens  medications  food  insect bites
- Does your child suffer from or has ever experienced, or is being treated currently for any of the following:  
 asthma  diabetes  heart trouble  epilepsy/seizure disorder  
 physical handicap  frequently upset stomach
- Date of last tetanus shot \_\_\_\_/\_\_\_\_/\_\_\_\_  
M Y
- Does your child wear  
 glasses  contact lenses
- Please list and explain any major illnesses the child experienced during the last year

Additional comments:

Should this child's activities be restricted for any reason? Please explain.



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**For your information, we expect each student to conform to these rules of conduct:**

- No possession or use of alcohol, drugs or tobacco
- No students can drive
- No fighting, weapons, fireworks, lighters or explosives
- No offensive or immodest clothing
- No boys in girls' sleeping quarters and no girls in boys' sleeping quarters
- Participation with the group is expected
- Respect property
- Respect one another, staff and adult leaders
- Respect and comply with event schedules

**Students who fail to comply with these expectations may be sent home at their parents' expense.**

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Student Name Student Signature M D Y

**Activities may include, but are not limited to:** cookouts, boating, water skiing, swimming, basketball, rollerskating, rollerblading, games in the park, soccer, broomball, ice skating, volleyball, softball, baseball, camping, downhill skiing, snowboarding, hiking, biking, concerts, Bible studies, golfing, miniature golf, hayrides. Note: If you desire to limit your child's participation in any event, please submit your wishes in writing to the church youth pastor prior to that event.

\_\_\_\_\_ has my permission to attend all youth activities sponsored by the FIRST PRESBYTERIAN CHURCH (herein after the "Church") from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.

I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by the Church. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the student ministries staff member.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent Name Parent Signature M D Y