

Children and youth Permission and Medical Information form

_____Presbyterian Church, _____, AL,

Contact Information**Youth:**_____
(First Name) (Last Name) (DOB)

Membership Church: _____

Mailing Address : _____

E-Mail: _____ Grade: _____ School: _____

Phone #'s: (Home) _____ (Cell) _____ Facebook: [] Yes [] No

Parents/Guardian:_____
(First Name) (Last Name) (Relationship)

Mailing Address: _____

E-Mail: _____ Facebook: [] Yes [] No

Phone #'s: (Home) _____ (Cell) _____ (Other) _____

Emergency Contacts: In case of emergency, where someone listed above cannot be reached, please contact:#1: _____
(First Name) (Last Name) (Relationship)_____
(Home) (Cell) (Work)#2: _____
(First Name) (Last Name) (Relationship)_____
(Home) (Cell) (Work)

Media Waiver

I grant permission for photos of my student to be used by the churches named above in paper, website and social media publication (check one): **Yes** [☐] **No** [☐]

Medical Information and Release

Permission is hereby granted for _____ participate in all children and youth activities sponsored by Southminster Presbyterian between June 2019-June 2020, inclusive.

I expect and hold my child to be responsible for his/her own actions, to be a cooperative member of the group so that these activities can be a positive means of fellowship. In granting this permission, the Southminster staff, and volunteers and the staff and volunteers of partner churches are released from any and all liability in the event of injury or accident. Church staff, Adult Advisers, and Volunteers are given permission to drive children in their vehicles and also give permission to secure emergency medical treatment as may be required during the period covered by this permission. The cost of such treatment shall be borne by the undersigned.

(Printed Name) (Signature) (Date)

Note: If possible, please attach a copy of back and front of medical insurance card.

Primary Insurance Information:

Insurance Company:_____

Address: _____ City _____ State _____ Zip _____

Contract/Policy #: _____ **Group #:** _____ **Date:** _____

Employee/Subscriber Name: _____

Address: _____ City _____ State _____ Zip _____

Secondary Insurance Information (if applicable)

Insurance Company:_____

Address: _____ City _____ State _____ Zip _____

Contract/Policy #: _____ **Group #:** _____ **Date:** _____

Employee/Subscriber Name: _____

Address: _____ City _____ State _____ Zip _____

The contact information you give will be used to create a Youth Contact Directory, available to volunteers, youth and their families. Medical information and release will be kept on file in the offices of the church where the particular youth is a member (or where a guardia n designates) and taken an any off campus activity in which the young person participates .

MEDICATION:

List all medications the youth will take during the trip noted above. This includes any prescription, non-prescription medications, herbal supplements and vitamins. Any participant under the age of 18 is required to give **ALL MEDICATIONS to the adult youth leader in their original containers with complete dispensing instructions before the start of the event.** Youth are not permitted to carry any prescription or non-prescription medication and will be sent home at the parent/guardian's expense if they do.

Medication Name	Dose	Treatment for	Dispensing instructions
<i>Example: Zyrtec</i>	<i>5mg</i>	<i>Seasonal allergies</i>	<i>Take one pill daily in the morning with food</i>
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Over-the-Counter Medication Permission: Do you give permission for your child/youth to be given over-the-counter medication as needed and as directed on the label, to treat non-emergency medical conditions that do not require a doctor or hospital visit such as a minor headache, stomachache, or allergic reaction (i.e. Tylenol, Advil, antacids, Benadryl) while at a youth ministry event?

- ☐ **No.** Contact me or get medical help if my child has any minor medical concerns.
Parent
signature _____
- ☐ **Yes.** I give permission for an adult youth leader to give my child approved over-the-counter medications as directed on an as needed basis to treat non-emergency medical conditions.
Parent
Signature _____

MEDICAL CONDITIONS: Please answer in detail if applicable or write N/A. Attach additional pages if necessary.

1. List any medical conditions you have (asthma, diabetes, epilepsy, etc.):
2. List any allergies (drug/medicine, food, and/or environmental) and the severity and type of reaction:
3. Please explain any other pertinent information about the participant (i.e. physical, behavioral, or emotional) that would be important for the adult leaders to know.