PARENTAL PERMISSION AND MEDICAL AUTHORIZATION FORM

Participant Name: _____ Birth date: _____

Street Address: _____ Participant's Primary Number: _____

City, State & Zip: _____ Email: _____

I give permission for my child (named above) to attend all supervised events, field trips, and service projects associated with the St. Paul's United Church of Christ except as noted:

I further give permission for my child to be transported to and from events by hired and volunteer drivers authorized by St. Paul's United Church of Christ

_____**Medical Release**

In the event of an emergency and I am unable to respond, I authorize the youth leaders or staff of St. Paul's UCC, hospitals, licensed medical or dental providers, and their agents and employees to have access to the information contained in this form and to provide all medical/dental treatment and necessary transportation advisable for the health and safety of my child. This authorization includes the authority to consent to any x-ray examinations, anesthetic, medical procedure or treatment, and hospital care, under the supervision and upon the advice of a physician or surgeon licensed under the Medical Practice Act or dentist licensed under the Dental Practice Act, for my child. I understand that I am responsible for payment of treatment.

_____**Custody Release**

I further authorize the youth leaders of St. Paul's UCC to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to said adult.

_____**Photo Release**

I also give permission to photograph and record (digitally and analog) my child and to use his/her image and sound prints in promotional materials for St. Paul's UCC.

Signature of Parent or Legal Guardian	**Printed name of Parent or Guardian**	**Date**

EMERGENCY CONTACT INFORMATION

Parent(s)/Guardian(s)

Name(s)	Parent(s)/Guardian(s) Primary Phone Number
Street Address	Parent(s)/Guardian(s) Secondary Phone Number
City State Zip	Parent(s)/Guardian(s) Email address

Other Emergency Contact

Name (1): Relationship to Participant:	Name (1) Phone

HEALTH CARE INFORMATION

Participant Name: _____

Physician	**Dentist**
Name	Name
Phone	Phone
Medical Insurance Company	Dental Insurance Company
Policy/Group Number	Policy/Group Number
Name of Policy Holder	Name of Policy Holder

Please list any allergies to drugs, foods, plants, insects, etc:

Please list any prescription medication to be taken by the participant (including what it is taken for, when it is to be taken, dosage information, and any special procedures):

Please list any non-prescription (over-the-counter) medication you do NOT want dispensed to your child:

Please list any additional information relevant to participating in youth activities (dietary needs; surgeries or serious injuries; chronic or recurring illness; medical conditions such as epilepsy or diabetes; mental health concerns, learning disabilities, any restrictions, etc.):

Information provided on this form will be kept strictly confidential.
Please complete this form, print it, sign it, and give it to the appropriate youth leader or pastor.