PERSONAL INFORMATION AND PARENTAL PERMISSION RELEASE AND CONSENT TO MEDICAL TREATMENT

The First Presbyterian Church at Caldwell, NJ
Youth Activities
September 2, 2019– September 1, 2020

Child's Full Name:_____

Birth Date:_____ Grade _____

Address:_____

City:_____ Zip Code:_____

Home Phone:_____ Child's Cell Phone: _____

Child's E-Mail: _____

Parent/Guardian(s) Name:_____

Parent Cell Phone(s):_____

Parent E-Mail(s): _____

The undersigned, being the parent, guardian, or managing conservator of (Child's name) _____, such child being under eighteen (18) years of age, does give permission for such child to accompany the group and participate in the youth activities sponsored by the THE FIRST PRESBYTERIAN CHURCH AT CALDWELL, NJ (hereafter FPC) and which may involve either traveling in church owned vans or in other buses or private vehicles.

I hereby release FPC, its staff, employees, drivers, sponsors and helpers from any liability for injury or damages suffered by the above child and agree to release, indemnify and waive any rights by subrogation I may have, and hold harmless FPC, its staff, employees, drivers, sponsors and helpers from injury or damages to my child.
I can be reached at the following telephone numbers:

(Home Phone)_____ (Work Phone)_____(Other Phone)_____

In the event I cannot be reached, I hereby authorize the following person to give consent for emergency medical treatment:

(Name)_____ (Home Phone)_____

(Work Phone)_____ (Other Phone)_____

My child is currently taking the following prescription medications on a regular basis (state medication and reason):

_____

_____

Additional information: _____

_____

Note: A form for medical permission for long-term prescriptions may be required for certain activities that are off-site.

Allergies: _____

_____

_____My child does not have any known allergies to medication.

_____My child is allergic to the following medication: _____

Blood Type: _____ Date of last tetanus shot:_____

I hereby consent and authorize the adult leader(s) accompanying my child to obtain emergency medical treatment in the case of injury or illness upon presentation of this authorization or a photocopy thereof. I understand that I am responsible for all charges incurred in medical treatment for my child. I understand that if payment is required at the time of service it is my responsibility to reimburse any person or institutions who covered the original cost.

Insurance Carrier: _____ Member #:_____

Name of Policy Holder: _____ Policy #:_____

Social Security # of Policy Holder:_____

Family Doctor (Name):_____Office Phone:_____

Address:_____ Answering Service:_____

Please staple a photocopy of the front/back of the insurance card with this form.

PLEASE NOTE THAT IT IS THE RESPONSIBILITY OF EACH PARENT, GUARDIAN OR MANAGING CONSERVATOR TO UPDATE THIS INFORMATION AS THE NEED ARISES.

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Signature of Parent, Guardian or Managing Conservator