

**PERSONAL INFORMATION AND PARENTAL PERMISSION RELEASE  
AND CONSENT TO MEDICAL TREATMENT**

**The First Presbyterian Church at Caldwell, NJ  
Youth Activities 2014**

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 2014 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.***

\_\_\_\_\_  
**Signature of Parent, Guardian or Managing Conservator**

\_\_\_\_\_  
**Date**