

Argyle Church of Christ

Parental Consent for Participation & Medical Release Form (Grades 6-12)

Name of Child _____ Home Phone _____

Address _____ City _____ ST _____ Zip _____

Date of Birth _____ Physician _____ Phone _____

Insurance Company _____ Policy Number _____

Parent/Guardian Names _____

Emergency Contact Numbers:

Name _____ Home _____ Cell _____ Work _____

Name _____ Home _____ Cell _____ Work _____

(Please Print Student's Complete Name Below)

_____ **has my permission to participate in youth activities sponsored by the Argyle Church of Christ, including transportation to and from the event or activity.** As the legal parent and/or guardian of the above signed child, I understand that in the event medical treatment is required, effort will be made to contact me. However, if I cannot be contacted, I give permission for my staff or sponsor, chaperones or youth minister to secure medical services to provide the care necessary for my child's well-being, including anesthesia, surgery or another treatment. I give the medical personnel authority to do whatever is necessary to protect the life of my child. I understand all expenses will be paid by me as the parent or guardian.

This release form will apply to all retreats, youth rallies, and any local or long distance trips or activities sponsored by the Argyle Church of Christ.

I also understand this form releases said staff/sponsors and chaperones/ministers and the Argyle Church of Christ from all legal liability in the event of an accident or incident.

Do we have permission to show your child's picture on our website? (no identifying information will be used with the picture) _____ YES _____ NO

****Do not sign form until in the presence of a notary***

Signature of Parent or Guardian _____
Date

The following information is to be completed and signed and sealed by a notary public:

STATE OF FLORIDA, COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____

By _____ who produced _____

_____ for identification.

PLEASE COMPLETE BOTH SIDES OF THIS FORM

MEDICAL INFORMATION FOR (NAME) _____

Allergies _____

Any medical or behavioral conditions we should be aware of ? (asthma, allergies, ADD, ADHD, etc...)

Date of last tetanus booster _____

Medications you child takes on a regular basis (prescription or over the counter):

Medicine _____

Dosage/Administration _____

Condition for which medicine is prescribed _____

Medicine _____

Dosage/Administration _____

Condition for which medicine is prescribed _____

Medicine _____

Dosage/Administration _____

Condition for which medicine is prescribed _____

- **Youth must bring their own medication for allergies ,asthma and other conditions.**
- **All over-the-counter medications must clearly be labeled with youth's name.**
- **Prescription medication should be in original container with original prescription label**
- **It is the parent's responsibility to let the Youth Minister know of any changes.**

**NOTE: This document may contain confidential medical/health care information.
Unauthorized disclosure to other than intended addressee may violate State and Federal Law.**

PLEASE COMPLETE BOTH SIDES OF THIS FORM