*First Baptist Church - Winslow*

*YOUTH ACTIVITY PERMISSION FORM*

**PLEASE READ AND SIGN THIS FORM. THIS FORM MUST BE SIGNED TO ATTEND THE FUNCTION**

Name of Child Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Relationship:

Address: Guardian Phone Number: Guardian Secondary Number:

Child’s Number:

**Consent:** I give permission for the Youth Leadership Team to use the information found on this permission form to provide needed care for my child. I understand the Youth Leadership Team will not be held responsible for any injuries or illnesses that my child sustains during the activities. I understand this information will be kept on file and used for emergencies. **If there are any changes in my child’s medical conditions I will complete a new form.**

**Dress Code:** I understand my child will be required to uphold a modest dress code that is founded on Biblical principles. The Youth Leadership Team is allowed to monitor my child’s clothing (a detailed list will be provided upon request).

**Discipline**: I understand that my child is under the supervision of the Youth Leadership Team. If there is a discipline problem the Youth Leadership Team will work toward resolution. If my child is uncooperative, I understand that I will be notified and my child may be sent home early from an event. If they are sent home early I agree to pay the required cost send them home or come and get them.

**Medical Treatment Authorization:** I understand that I will be notified in the case of a medical emergency. However, in the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event that my child is injured or becomes ill. I authorize the Pastor(s) and/or the Youth Leadership Team to make emergency medical care decisions on behalf of my child, if required by law or a health care provider. I authorize these persons to act in my place to consent to all necessary and appropriate x-ray examinations, anesthetic, medical or surgical diagnosis or treatment, and hospital care. I understand that these persons will not be responsible for medical expenses incurred solely on the basis of this authorization.

**Over the Counter Medication:** Please check one: I DO authorize\_\_\_\_\_\_\_ I DO NOT authorize\_\_\_\_\_\_\_\_:

the Pastor(s) and/or the Youth Leadership Team to provide/administer over-the-counter medication (examples - Tylenol, upset stomach, eye drops, etc.). They may administer prescribed medications listed on the back of this document as requested by the parent/guardian accounting to the dosages on the medication.

I have listed on the reverse side of this form all medications, allergies, and medical information/conditions related to my child and this trip.

Printed Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

**CONFIDENTIAL**

Information provided on this form will be kept strictly confidential with the Adult Youth Leadership Team.

Name of Child Date of Birth

Is your youth presently being treated for an injury or sickness or taking any medication? 🞏 Yes 🞏 No

If yes, please explain.

Does your child have, or has your child ever had, any of the following? (Please check all that apply.)

🞏 Asthma 🞏 Hay Fever 🞏 Allergies 🞏 Diabetes 🞏 Migraines

🞏 Fainting spells 🞏 Seizures 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please explain.

Please list any medication and dosages your child is taking.

Are you are sending medications for your child on this trip? 🞏 YES 🞏 NO

Do you expect that the child will use this medication on this trip? 🞏 YES 🞏 NO

**To prevent loss and/or misuse, please give any medication that will/may be taken on a trip or at an event to a member of the Youth Leadership Team.**

Does your child have a physical handicap or illness that would prevent him or her from participating in normal rigorous activity? 🞏 YES 🞏 NO

If yes, please explain.

Family Doctor: Doctor’s Telephone:

Insurance Company:

Name on Card:

Policy Number:

(Please attach a copy of insurance card.)

The information provided here is correct and may be used as needed during the trip or activity. I will notify the Adult Youth Leadership Team if this information changes or I feel there any health considerations that would prevent my child’s participation in any activities.

PRINT Name of Parent/Guardian:

SIGNATURE of Parent/Guardian: Date