

# PARENTAL CONSENT FORM for May 1, 2017— October 1, 2018

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_  
 Parent(s) cell phone \_\_\_\_\_ Family doctor/phone \_\_\_\_\_

The undersigned does hereby give permission for our (my) child \_\_\_\_\_, to attend and participate in **all youth fellowship events** sponsored by The Presbyterian Church, Basking Ridge, NJ.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with medical and dental services rendered to above named individual pursuant to this authorization.

Should it be necessary for our/my child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for our/my child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by The Presbyterian Church, Basking Ridge, NJ.

The undersigned does also release The Presbyterian Church, Basking Ridge, NJ, its employees and volunteers from any responsibility and liability for injury, damages or loss occurring during the aforementioned activity to our/my child who, with the undersigned, assumes all risks in the use and enjoyment of said activity.

Insurance company \_\_\_\_\_ Policy number \_\_\_\_\_

\_\_\_\_\_  
 Parent or legal guardian name (*please print*) \_\_\_\_\_ Signature of Parent or legal guardian \_\_\_\_\_ Date \_\_\_\_\_

Emergency phone number(s) \_\_\_\_\_

Please list any allergies (to medication or food) or medical concerns your child may have:

\_\_\_\_\_  
 \_\_\_\_\_

Please list any other pertinent information: \_\_\_\_\_

\_\_\_\_\_

List any and all medication youth is presently taking (this information is kept confidential):

Name of medication	Dosage	Reason for medication	Can your child self-medicate?

Date of last tetanus shot \_\_\_\_\_ Blood type (if known) \_\_\_\_\_

Is the youth currently being treated for any medical problems? \_\_\_Yes \_\_\_No

If so, please provide the following: Medical condition being treated \_\_\_\_\_

Doctor's name & telephone number (if different from above) \_\_\_\_\_

Do we have your permission to post your child's photo on our website/social media? \_\_\_Yes \_\_\_No