

YOUTH MEDICAL CONSENT FORM for May 1, 2020 - October 1, 2021

Name _____ Age _____ Birthdate _____
 Address _____ Youth Cell _____
 City _____ State _____ Zip Code _____
 School _____ Grade _____
 Parent/Guardian name _____ Cell phone _____
 Parent/Guardian name _____ Cell Phone _____
 Family doctor _____ Phone _____
 Last tetanus shot _____ Blood type (if known) _____

The undersigned does hereby give permission for our (my) child _____, to attend & 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 afore-mentioned activity to our/my child who, with the undersigned, assumes all risks in the use & enjoyment of said activity.

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

Insurance company _____ *Policy number* _____

_____ *YES, I have attached a copy of current medical card to this form or scanned and emailed it to jleotti@brpc.org*
This is REQUIRED, if youth is insured.

Please list any ALLERGIES (to medication or food) and any MEDICAL or EMOTIONAL 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): (*You may continue on back*)

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

Is the youth currently being treated for any medical/emotional problems? ___ Yes ___ No

If so, please provide the following: condition being treated _____

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

Do we have permission to post your child's photo and/or 1st name on our website/social media? ___ Yes ___ No
 (NOTE: Last names of youth will NOT be included in any postings.)