

Community Baptist Church
Parental Consent & Medical Release Form
Please fill out completely and sign

Student's Name _____ Circle: Male Female
Date of Birth _____ Age _____ Grade _____
Address _____
City _____ ZIP _____
Parent Name(s) _____ Phone _____
Address (if different from student) _____
City _____ ZIP _____
Cell Phone _____ Email _____
Work Phone: Father _____ Mother _____

AUTHORIZATION TO CONSENT TO TREATMENT

I/We hereby give my/our permission for my/our child _____ to attend Community Baptist Church sponsored youth events beginning in the month of June 2010 and ending in the month of June 2011. I/We understand that there will be adult supervision at these events. I/We also understand that if there are any disciplinary problems with the above named teen, it will be our responsibility to pick-up our child at the site of the event and they will not be eligible for future events without specific approval of the Community Baptist Church Youth Pastor or authorized leadership. I/We understand these programs/events occur both on Community Baptist Church campus as well as other locations off campus.

I (We), the undersigned, parent(s)/guardian(s) of the child named above on this consent form, do hereby authorize Community Baptist Church, its staff, our representatives, as agent(s) for the undersigned to consent to medical treatment, including x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care to be rendered to the minor under the general or medical staff of a licensed hospital, whether such a diagnosis or treatment is rendered at the office of the said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment of hospital care which the aforementioned physician in the exercise of his/her best judgment deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California which allows Parent(s) or Guardian(s) to authorize any adult to consent to medical or dental treatment as stated in the above paragraphs.

Signed _____ Date _____
Parent or Legal Guardian

Print Name _____

___ Check here if you **do not** want your child's photos used in promotional materials or used on CBC's website.



Medical Information

Medical Insurance _____ Policy # _____
Claim Office Address _____ Phone _____
Employer Name/Address _____
Dr. Name and Phone # _____
Dr. Address _____

Health History

To protect your child from possible embarrassment and to better ensure his/her safety, but not to exclude him/her from the program, the following information is requested. Place a check next to each appropriate item and give approximate dates if possible.

General

Frequent Ear Infections _____	Hay Fever _____
Heart defect/disease _____	Insect bites/stings _____
Convulsions _____	Diabetes _____
Bleeding/clotting disorders _____	Bed wetting _____
Sleep walking _____	Known allergies _____
Operations or serious injuries _____	
Other conditions or diseases _____	

1. Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity? Yes _____ No _____ If yes, please explain _____

2. In the event of a minor illness (such as a cold or headache), do you authorize the Leadership of Community Baptist Church to give your child common remedies such as Tylenol, cough medicine, etc. in dosages appropriate for his/her age? Yes _____ No _____
Please list any specific instructions _____
3. Please list any medications that your child will need to be taking during any camps or overnight Youth events.

Medication:

Dosage:

When taken:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other information you would like us to know

