



First Presbyterian Church

1900 North D Street • San Bernardino, California 92405 • 909.882.3308

Children/Youth Activity Medical / Permission Form

One form per participant. Please use blue or black ink, or type.

**ACTIVITY
INFO**

Activity Name: _____ Date(s): _____
Location Name: _____
Address: _____ City, State, Zip: _____
Primary Adult Leader: _____ Phone: (____) _____

**STUDENT
INFO**

Name: _____ Birthdate: ____/____/____ Gender: _____
Address: _____ Cell Phone: (____) _____
City, State, Zip: _____ Home Phone: (____) _____
E-mail: _____ Other Phone: _____

**GUARDIAN
#1**

Name: _____ Work Phone: (____) _____
Relationship to Student: _____ Cell Phone: (____) _____
Address: _____ Home Phone: (____) _____
City, State, Zip: _____ E-mail: _____

**GUARDIAN
#2**

Name: _____ Work Phone: (____) _____
Relationship to Student: _____ Cell Phone: (____) _____
Address: _____ Home Phone: (____) _____
City, State, Zip: _____ E-mail: _____

**MEDICAL
INFORMATION**

Primary Physician: _____ Office Phone: (____) _____
Dentist: _____ Office Phone: (____) _____
Medications (name, dosage & frequency): _____

Other medical information (known injuries, disabilities, allergies, etc.): _____

Insurance Carrier: _____ Policy No: _____
Address: _____ Phone: (____) _____
City, State, Zip: _____

**PARENTAL/GUARDIAN
PERMISSION**

I/We, _____, the parent or legal guardian of the above-named minor, hereby give my permission for his/her participation in the activity(ies) named above and agree to direct my child to cooperate and conform to directions and instructions of personnel and adult volunteers responsible for the activities.

I/We agree that in the event my child is injured as a result of his/her participation in the above-named activities, including transportation to and from these activities—whether or not caused by the negligence (active or passive) of the activity or the church program, or any of its agents, volunteers or employees—recourse for the payment of any hospital, medical, dental, or related costs and expenses will be paid either by me/us, or my/our accident, hospital or medical insurance, or any available benefit plan of mine/ours.

I/We consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physical, surgeon, and dentist licensed under the Medical Practice Act and Dental Practice Act. I/we am/are responsible for the health care decisions of my/our child and am/are authorized to consent to services to be rendered, and no other consent is required by law.

I/We hereby give permission to the physician selected by the activities supervisory personnel then present to render medical treatment deemed necessary and appropriate by the physician or dentist.

Signature of Parent/Guardian #1

Date

Signature of Parent/Guardian #2

Date