

## PERMISSION AND MEDICAL CONSENT

As parent or legal guardian, I hereby give permission for my child to participate in activities organized by West Virginia Convention of Southern Baptists:

Child's Full Name \_\_\_\_\_

Sex \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian Name \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

If not available in an emergency, notify:

1. Name \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Name \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Does this child have any of the following allergies: Penicillin \_\_\_\_\_

Other \_\_\_\_\_

Other drugs \_\_\_\_\_

Insect Bites \_\_\_\_\_

Ivy Poisoning, etc. \_\_\_\_\_

Hay Fever \_\_\_\_\_

Does this child have any medical or health problems, and has this child had any chronic or recurring illness or illnesses, which would have an effect on the child's participation in this activity? ( )Yes ( )No

If yes, describe the problems or illnesses \_\_\_\_\_

State the name, address, medical specialty and phone number of this child's family physician and of any other physician who should be consulted in the event of emergency or medical problems involving this child:

\_\_\_\_\_

\_\_\_\_\_

State the name, address, and phone number of this child's dentist (and orthodontist if applicable): \_\_\_\_\_

\_\_\_\_\_

Is there medical or hospitalization insurance which provides benefits for this child?

\_\_\_\_\_ if so, please indicate:

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Policy No. of Insurance Policy \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Phone No. of Insurance Co. \_\_\_\_\_

\_\_\_\_\_

Indicate the date of this child's last tetanus shot

Are there any activities, such as strenuous activities, to be restricted for this

Student \_\_\_\_\_ if so, list them \_\_\_\_\_.

Is this student on any medication? \_\_\_\_\_ If so, please state the medication:

\_\_\_\_\_.  
If so, will this student be bringing to the activity the medications that he/she should be taking? \_\_\_\_\_

Describe any dietary restrictions that this student is required to observe \_\_\_\_\_

\_\_\_\_\_

I further understand that, in the event my child requires medical or dental treatment while engaged in the Activity, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the ministry's sponsor or any adult counselor acting on behalf of the ministry with respect to the activity, as agent for me, to consent to any X-ray examination; injections, anesthesia, medical, dental, or surgical diagnosis and treatment, and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medications being taken, medical problems and other pertinent information. My child has my permission to participate in all prescribed activities except as noted by me.

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I the undersigned, do hereby release, remiss, and forever discharge all sponsors of entity and/or church (listed above), and all claims, demands, actions or cause of action, past, present, or future arising out of any injury my child had while participating in the said event or activities.

I also understand that this permission slip will stay on file at the church for use during the year. This form is only good for one year from the date signed.

\_\_\_\_\_  
(Parent or Guardian signature)

In witness whereof I have here unto affixed my seal this \_\_\_\_\_ day of

at \_\_\_\_\_ city \_\_\_\_\_ county.

\_\_\_\_\_  
NOTARY PUBLIC