PERSONAL INFORMATION AND PARENTAL PERMISSION
RELEASE AND CONSENT TO MEDICAL TREATMENT

The First Presbyterian Church at Caldwell, NJ

September 2018-August 2019 Youth Activities

Child's Full Name_____

Birth Date_____ Grade_____

Address_____

City_____ Zip Code_____

Home Phone_____ Child's Cell Phone_____

Child's Email _____

Parent/Guardian(s) Name_____

Parent Cell Phone(s)_____

Parent Emails_____

The undersigned, being the parent, guardian, or managing conservator of (Child's name)_____, such child being under eighteen (18) years of age, does give permission for such child to accompany the group and participate in the 2018/2019 youth activities sponsored by the FIRST PRESBYTERIAN CHURCH AT CALDWELL, NJ (hereafter FPC) and which may involve either traveling in church owned vans, or in other buses or private vehicles.

I hereby release FPC, its staff, employees, drivers, sponsors, and helpers from any liability for injury or damages suffered by the above child and agree to release, indemnify and waive any rights by subrogation I may have, and hold harmless FPC, its staff, employees, drivers, sponsors and helpers from injury of damages to my child.

I can be reached at the following telephone numbers:
(Home)_____ (Work)_____

(Cell)_____

In the event I cannot be reached, I hereby authorize the following person to give consent for emergency medical treatment:

(Name)_____ (Home) _____

(Work)_____ (Cell)_____

My child is currently taking the following prescription medications on a regular basis (state medication and reason):

_____

_____

Additional Information_____

Note: *A form for medical permission for long-term prescriptions may be required for certain activities that are off-site.*

Allergies_____

_____

_____ My child does not have any known allergies to medication.

_____ My child is allergic to the following medication: _____

Blood Type_____ Date of last tetanus shot_____

I hereby consent and authorize the adult leader(s) accompanying my child to obtain emergency medical treatment in the case of injury or illness upon presentation of this authorization or a photocopy thereof. I understand that I am responsible for all charges incurred in medical treatment for my child. I understand that is payment is required at the time of service, it is my responsibility to reimburse any person or institutions who covered the original cost.

Insurance Carrier_____ Member #_____

Name of Policy Holder_____ Policy #_____

Family Doctor (Name)_____ Office Phone_____

Address_____ Answering Service_____

Please staple a photocopy of the front AND back of the insurance card with this form.

PLEASE NOTE THAT IT IS THE RESPONSIBILITY OF EACH PARENT, GUARDIAN OR MANAGING CONSERVATOR TO UPDATE THIS INFORMATION AS THE NEED ARISES.

Signature of Parent, Guardian or Managing Conservator