First Church of God Parental Consent Form

Student’s Name Age Birth Date

Address Cell #

City State Zip Code

School Grade

Parent’s/Guardian’s Names

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

Parents Cell Phone(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone (s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To Whom It May Concern:**

The undersigned does hereby give permission for our (my) child, ,

 (Name of Child)

to attend and participate in all activities & all trips sponsored by First Church of God, Chillicothe, Ohio, for the period of \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_–\_\_\_\_/\_\_\_\_/\_\_\_\_.

 (Start Date) (End Date)

We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned youth pursuant to this authorization. We (I) do hereby release, forever discharge and agree to hold harmless the First Church of God, Chillicothe, Ohio, and the directors thereof from any and all liability, claims or demands for personal injury, sickness, or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the child-participant that occur while said child-participant is participating in the above described trip or activity.

Furthermore, we (I) (and on behalf of our (my) child-participant), hereby assume all risk of personal injury, sickness, death, damage, and expense as a result of participation in recreation and work activities involved therein.

Further, authorization and permission is hereby given to said church to furnish any necessary transportation, food, and lodging for this participant.

The undersigned further hereby agree(s) to hold harmless and indemnify said church, its directors, employees, and agents, for any liability sustained by said church as the result of the negligent, willful, or intentional acts of said participant, including expenses incurred attendant thereto.

Hospital Insurance: ❑ Yes ❑ No

Insurance Company & Policy Number:

Emergency Phone Numbers:

**If child resides with both parents, then both signatures are required. If child resides with custodial parent, said parent should sign and present proof of custody.**

Mother Date

Father Date

Legal Guardian (if applicable) Date

Physician Physician’s Phone #

Is your child having any of the problems listed below? (Circle all numbers that apply)

1. Hay fever, asthma, or wheezing 6. Frequent colds, sore throat, or earache

2. Eczema or frequent skin rashes 7. Shortness of breath

3. Convulsions/seizures 8. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Heart trouble

5. Diabetes

**\*\*\* Please explain any problem areas identified above in the “Remarks” section.**

 History of emotional/behavioral disturbance? ❑ Yes ❑ No

(If yes, explain in “Remarks” section.)

Is medication needed or used by the child? ❑ Yes ❑ No

Special conditions to watch for, such as allergy (food/drugs),
sleep walking, fainting, etc. (If yes, explain in “Remarks”) ❑ Yes ❑ No

Does your child have any special dietary needs? ❑ Yes ❑ No

My child/charge has had all immunizations required by the health department: ❑ Yes ❑ No

If no, explain in “Remarks.)

Also, please give date of the last tetanus booster:

Should the child’s activity be restricted because of any physical defect or illness? ❑ Yes ❑ No

(If yes, please explain the degree of restriction in “Remarks.”)

**Please Note:** All medications are to be submitted to the head counselor before departure on a trip. Please see that these medications are in their original containers and that the child’s name is on it. The child is responsible for taking his/her medication(s).

Is your child/charge allowed to swim? ❑ Yes ❑ No

What is his/her swimming ability? ❑ Poor ❑ Fair ❑ Good

Remarks: Please put any remarks on the back of this page.

**Remarks:**