



First Christian Church
Disciples of Christ
RICHMOND, KENTUCKY

First Christian Church Youth Medical Release & Permission Form

Effective Dates: August 1, 2011—August 31, 2012

Name of Youth: _____ Sex: M F
First Middle Last

Address: _____
Street City State Zip Code

Birthday: ___/___/____ Age: ___ Email: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

School: _____ Grade: _____ Facebook: Yes or No

Parent or Guardian: _____ Relationship: _____

Address: _____
Street City State Zip Code

Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____
Home Work Cell

Email: _____

Emergency Contact: (Not Parent)

Name: _____ Relationship: _____

Phone Number: (____) _____ - _____

Insurance Provider: _____

Policy Number: _____ Group Number: _____

Primary Care Physician: _____ Phone: (____) _____ - _____

Medical History: If applicable, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability or condition in which the Youth Leaders should be aware.

Current Medications (include dose & frequency): _____

Allergies/Special Dietary Needs: _____

May a Youth Leader or church representative give your child over the counter medications if necessary (i.e., Tylenol, Ibuprofen, antacid, etc)? Yes No

By signing below, I affirm that the above information is correct to the best of my knowledge and I give my permission for _____ to participate in activities at First Christian Church, Richmond, KY and to ride with Youth Leaders and church representatives (staff, ministers, parents & volunteers) on church trips. I understand this may be by bus, van or private vehicle. I also give permission for my child to be photographed at church events and for those photos to be shared and used in church communication. I release First Christian Church (Disciples of Christ) of Richmond, KY from any responsibility for injury or damages my child may incur while participating in church organized events. I hereby authorize staff and volunteers of First Christian Church of Richmond, KY to consent to medical treatment for the above named child and admission to any hospital or treatment facility if recommended by a physician. I also understand that every attempt will be made to notify me as soon as possible should an emergency arise. I will be responsible for the charges for any medical treatment or hospitalization rendered by reason of this authorization.

Printed Name: _____ **Relationship:** _____

Signature: _____ **Date:** ___ / ___ / _____