

PALM CITY PRESBYTERIAN CHURCH
Palm City, Florida

(To be filled out by parents and returned as soon as possible. Information is confidential.)

Name _____ Age _____ Date of Birth _____ Sex _____

Address (complete) _____

Parent/Guardian _____

Business Address _____

Person to contact in emergency _____ Phone: _____

Telephone (home) _____ (beeper) _____

(Mom cellular) _____ (Mom office) _____

(Dad cellular) _____ (Dad office) _____

E-mail Address: _____

HEALTH INFORMATION NECESSARY FOR PROPER CARE AND PROTECTION

1. Describe any health factor that makes it advisable for your son/daughter to limit physical activity:

2. Please state any limitations: _____

3. Allergic to medications: Yes No (If "Yes", please list) _____

4. Name of family physician: _____

Address/Phone: _____

5. May have ibuprofen/acetaminophen: Yes No

5. Allergic to foods: Yes No If so, what: _____

6. Additional information needed concerning your child: _____

This form pertains to all youth involved in Youth Group, Children's Programs, Vacation Bible School, special activities and retreat programs of Palm City Presbyterian Church between the dates of June 1, 2010 and August 31, 2011.

If a serious emergency arose, it might be necessary for a physician to attend your son/daughter before the staff could get in touch with you or your designated physician. Such care can be provided ONLY if you sign the following AUTHORIZATION FOR MEDICAL TREATMENT.

I, the undersigned parent or legal guardian of _____, a minor, do hereby authorize and consent to an X-ray, examination, anesthetic, medical or surgical diagnosis or treatment rendered by a licensed M.D. or those under the supervision of the M.D. In the event emergency treatment by a rescue unit is indicated, my approval is also given. I further authorize the representative of this form to select a medical doctor and/or hospital of his or her choice for the purpose of diagnosis or treatment of the above-named minor.

It is understood that the authorization is given in advance of any specific authority and power to render care, which the aforementioned physician in the exercise of his best judgement, may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the above-named minor, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Signature _____ Relationship _____

Insurance Agent/Company _____

Policy number _____

This form shall remain effective from June 1, 2010 to August 31, 2011 .

PARENT PERMISSION

I, (parent or guardian), _____ hereby release and discharge all Session-approved Youth Advisors and other chaperoning adults from all claims of damage, demands, actions whatsoever in any manner arising or growing out of my son or daughter's participation in trips approved by the Christian Education Committee and Session of Palm City Presbyterian Church. Except for those limitations named on this health form, I certify that _____ is healthy and fit to participate.

Dated: _____ Signature: _____

Print Name: _____