

PARENTAL CONSENT FORM

Date: ____/____/____
Updated every September.

NAME _____ AGE ____ BIRTHDATE _____
ADDRESS _____
CITY _____ STATE ____ ZIP CODE _____
TELEPHONE (____) _____ GRADE IN OR COMPLETED _____
PARENT(S) BUSINESS TELEPHONE NUMBERS: (____) _____ Dad
(____) _____ Mom
(____) _____ Cell #

PARENTAL CONSENT:

The undersigned does hereby give permission for my child, _____ to attend and participate in the youth activities sponsored by Immanuel UMC in Ripon, Wisconsin.

As parent or guardian, 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 hospital care.

The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization. Should it be necessary for my child to return home due to medical or disciplinary reasons, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for my child to ride in any vehicle designated by the Director of Youth & Family Ministries while attending and participating in activities sponsored Immanuel UMC in Ripon, Wisconsin.

Student's Signature _____ (Signature)

Parent or Guardian _____ (Please Print)
_____ (Signature)

PARENT AND STUDENT AGREEMENT:

We (parent and youth) understand that inappropriate behavior towards another group member, private party, church property, vehicles, the property or persons or churches we may visit during an event may result in the youth being financially liable for their actions. In the event of property damage, the student and parent agree to reimburse all damages caused by the student.

Student's Signature _____ (Signature)

Parent or Guardian _____ (Please Print)
_____ (Signature)

Please complete the reverse side, Medical Form. Thanks.

MEDICAL FORM

Immanuel United Methodist Church – Ripon, WI

NAME	BIRTHDATE	
THINGS WE NEED TO KNOW		
Check Boxes That Apply		
<p>Allergies</p> <p><input type="checkbox"/> Food _____</p> <p><input type="checkbox"/> Peanuts</p> <p><input type="checkbox"/> Seasonal - Season _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin</p> <p><input type="checkbox"/> Other Drugs _____</p>	<p><input type="checkbox"/> Heart Condition</p> <p><input type="checkbox"/> Convulsions/Seizures</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Frequent Stomach Upset</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Hearing Aid</p> <p><input type="checkbox"/> Diabetic – Insulin Dependent <input type="checkbox"/>Y <input type="checkbox"/>N</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Contacts</p> <p><input type="checkbox"/> Migraine</p>
RECORD OF SICKNESS/IMMUNIZATION		
Check Boxes That Apply		
<p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Polio</p>	<p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Immunization Tetanus (Booster) _____</p>	
MEDICATIONS/DIETARY NEEDS		
<i>Please Insure That Your Son/Daughter Has These With Them At All Activities (ie. Inhalers)</i>		
<p>Are there any routine treatments or medications required by your child on a daily basis?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes If yes please list: _____</p> <p style="margin-left: 100px;">_____</p> <p style="margin-left: 40px;"><input type="checkbox"/> The student can take on their medication on their own.</p> <p style="margin-left: 40px;"><input type="checkbox"/> The student must have this administered by an adult.</p> <p>Are there any special dietary needs?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes If yes please list: _____</p> <p style="margin-left: 100px;">_____</p>		
INSURANCE/DOCTOR INFORMATION		
<p>Hospital Insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes Insurance Company: _____</p> <p>Doctor's Name: _____ Insurance Policy #: _____</p> <p>Doctor's Phone #: (____) _____ Dentist/Orthod. #: (____) _____</p> <p>Dentist/Orthodontist. Name: _____</p>		
PARENT OR GUARDIAN SIGNATURE: _____		