

## PARENT PERMISSION/RELEASE – CULLOWHEE BAPTIST CHURCH

The following information will be kept confidential and will accompany the group any time they travel.

\_\_\_\_\_ has my permission to participate in Cullowhee Baptist Church's children and youth program from \_\_\_\_\_, 2020 to December 31, 2020.

I understand that there are certain inherent dangers that exist in the activities that are provided during the program. Students will be transported to and from various activities by personal vehicles. Students will participate in a variety of group activities and games that will be held outdoors. Injuries can occur from numerous methods and can result in cuts, scrapes, burns, contusions, avulsions, fractures, concussions, and even paralysis or death. In case of an emergency involving my child, I understand that efforts will be made to contact me. In the event I cannot be reached, permission is hereby given to the medical provider to secure proper treatment.

I also authorize the use of my/my student's photograph in the publications related to the promotion of the church programs.

## EMERGENCY CONTACT FORM - CULLOWHEE BAPTIST CHURCH

(Please print)

Child's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent(s) or Legal Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_ Mother ☐ Father ☐ Guardian ☐

Cell Phone: \_\_\_\_\_ Mother ☐ Father ☐ Guardian ☐

Cell Phone: \_\_\_\_\_ Mother ☐ Father ☐ Guardian ☐

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Important Information: \_\_\_\_\_

\_\_\_\_\_

## MEDICAL INFORMATION – CULLOWHEE BAPTIST CHURCH

Please complete the following medical information as thoroughly as you can. This will enable the church to better administer to your child's needs.

1. Does your child have any medical or physical condition which may limit your child's participation in church activities? YES\_\_\_\_ NO \_\_\_\_ If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

2. Does your child have any problems with allergies, hay fever, asthma, or other respiratory issues that require medication (inhaler, etc.)? YES\_\_\_\_ NO \_\_\_\_

If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. No oral medication will be given without written permission. The following non-prescription drugs may be given by a church leader if deemed necessary to relieve minor pain and discomfort.

- a. Tylenol YES\_\_\_ NO \_\_\_
- b. Ibuprofen YES\_\_\_ NO \_\_\_
- c. Benadryl YES\_\_\_ NO \_\_\_
- d. Pepto-Bismol / Antidiarrheal YES\_\_\_ NO \_\_\_
- e. Cough drops/throat lozenges YES\_\_\_ NO \_\_\_
- f. No medication should be given due to my convictions \_\_\_

4. If prescription medication is to be given for any reason, please fill out the following:

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time given: \_\_\_\_\_ Reason for medication: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time given: \_\_\_\_\_ Reason for medication: \_\_\_\_\_

5. Has your child evidenced an adverse allergic reaction to bee or wasp stings; or is he/she predisposed due to family medical history. YES\_\_\_ NO \_\_\_ If YES, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

6. Does your child have food allergies or ethical choices that require attention?

No \_\_\_\_\_

Yes \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

7. Date of child's last tetanus booster: \_\_\_\_\_

8. Insurance Co.: \_\_\_\_\_ Policy#: \_\_\_\_\_

Child's Doctor: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

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I, \_\_\_\_\_ parent/guardian for \_\_\_\_\_ hereby authorize a medical doctor, nurse, or other trained provider to administer required medical attention to my child should an emergency occur.

**All information contained herein is accurate and complete:**

Signature Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_