Westminster Presbyterian Church
2024-2025 Youth Fellowship

MEDICAL CONSENT FORM

Name _____ Age _____ Birth date _____

Mailing Address _____
Street City State Zip code

Home Phone _____Cell Phone _____

E-mail _____

School _____ Current Grade _____

To whom it may concern:

The undersigned does hereby give permission for our (my) child, _____ to attend and participate in the Youth Fellowship Program sponsored by Westminster Presbyterian Church, June 2024 through August 2025.

We (I) authorize the adult advisors, 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 or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physicians 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 child pursuant to this authorization.

Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult advisors in whose care the minor has been entrusted while attending and participating in activities sponsored by Westminster Presbyterian Church.

Hospital Insurance ____ Yes ____ No

Insurance Company _____

Policy Number _____

Emergency Contact other than parent or legal guardian

Name_____ _____ Phone _____ Relationship _____

FORM CONTINUES ON REVERSE SIDE or SECOND PAGE

Please list all medications your child takes on a regular basis, the purpose of the medication and the dosage:

Please list any medical conditions (asthma, diabetes, etc.) your child has that we should be aware of, along with instructions for handling the condition.

May we give your youth non-aspirin pain medication if they request it? ___ Yes ___No
If you answered yes, what dosage _____

Please list <u>all</u> allergies.

Please list anything that will limit your child's participation in planned activities, along with any other information you feel we should have.

_____ _____
Participant's Signature Date

_____ Cell Phone _____
Parent's Signature
Home/Work Phone _____

_____ Cell Phone _____
Parent's Signature
Home/Work Phone _____

_____ Cell Phone _____
Legal Guardian's Signature
Home/Work Phone _____