Impact Student Ministry of First Evangelical Church
PARENTAL MEDICAL CONSENT FORM

Name______________________________ Age________ Birthdate__________________
Address____________________________ Phone (_____) ______________________
City__________________ State________ Zip Code __________________________
School_____________________________ Graduation Year_______________________

Parent(s) business phone Father_____________________________________
Mother_____________________________________
Alternate Contact ____
Home Phone_________________________ Work Phone______________________

To whom it may concern:

The undersigned does hereby give permission for our (my) child, ______________________
____________________, to attend and participate in activities sponsored by Impact, the Junior High Student Ministry of First Evangelical Church.

After failed attempts to contact us (me), we (I) authorize the adult Impact Staff, 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 physician 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 cost.

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

____
Participant Date

____
Father Date

____
Mother Date

____
Legal Guardian Date

Hospital Insurance Yes_______ No _______

Insurance Company_________________

____

Policy Number_____________________

Health History:
Allergies

- Drugs
- Asthma
- Hay Fever
- Insect Stings
- Epilepsy
- Diabetes
- Cardiac
- Chronic Asthma
- Nervous Disorder
- Other
- Physical Handicap
- Emotional Handicap
- Mental Handicap
- Seizure Disorder

Date of last Tetanus Shot_________

If you have circled any of the above, please give details ______________________
____
Activity Restrictions____