

Fresno Bible Church – Youth Ministries

Parental Medical Consent Form

Name _____ Age _____ Birth date _____
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 the Fresno Bible Church Youth
Ministry.

After failed attempts to contact us (me), we (I) authorize the adult Fresno Bible Church 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 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 costs.

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 Fresno Bible Church Youth Ministry.

The medical consent and liability waiver provisions hereof shall remain in full force
throughout 2011-2012 and in effect until written notice of revocation or withdrawal is received by
Fresno Bible Church at its office at Po Box 67, Fresno, OH 43824. It is the responsibility of the
parent or guardian to notify the church of any change in medical condition, guardianship, address or
phone change in writing to the address as listed above.

_____	_____	Social Security # _____
Participant	Date	Hospital Insurance Yes _____ No _____
_____	_____	Insurance Company _____
Father	Date	Policy Number _____
_____	_____	
Mother	Date	
_____	_____	

Legal Guardian

Date

Health History:

Allergies

Drug

Diabetes

Physical Handicap

Asthma

Cardiac

Emotional Handicap

Hay Fever

Chronic Asthma

Mental Handicap

Insect Stings

Nervous Disorder

Seizure Disorder

Epilepsy

Other

If you have checked any of the above, please give details _____

Date of Last Tetanus Shot _____

Current Medication(s) _____

Special Diet _____

Activity Restrictions _____

Other Important Medical Information _____
