

## Parental Consent Form

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
School \_\_\_\_\_ Grade in or just completed \_\_\_\_\_  
Parent(s) work phone \_\_\_\_\_ Parent(s) cell or home phone \_\_\_\_\_  
\_\_\_\_\_

To whom it may concern:

The undersigned does hereby give permission for our/my child \_\_\_\_\_ to attend \_\_\_\_\_ and participate in activities sponsored by Highland Park United Methodist Church.

We/I, authorize an adult, in whose care the minor has been entrusted, to consent to any x-ray examination, aesthetic, 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 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 Highland Park United Methodist Church. We unconditionally release both Highland Park United Methodist Church and leaders or all claims.

Hospital Insurance:  yes  no

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Participant Name \_\_\_\_\_ Date \_\_\_\_\_

Mother signature \_\_\_\_\_ Date \_\_\_\_\_

Father signature \_\_\_\_\_ Date \_\_\_\_\_

Legal Gaurdian signature \_\_\_\_\_ Date \_\_\_\_\_

Please list any allergies or special medical problem your child may have.

In the event we are unable to contact you in an emergency, whom should we contact next?

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_

Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_