PARENTAL RELEASE AND CONSENT FORM

IMMANUEL CHURCH OF THE CHRISTIAN & MISSIONARY ALLIANCE
800 S. Market Street, Mechanicsburg, PA 17055

Student's Name: _____ DOB_____ Phone_____
Address: _____

Parents'/Guardians' Names: _____
Address (if different from student)_____
Phone: _____ 2nd Phone_____

Emergency Contact: Name: _____ Phone: _____
(If parent cannot be reached at other numbers)

Medical Insurance Information: Company: _____
Policy #: _____ Phone: _____

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PLEASE SELECT ONE OF THE FOLLOWING AS APPROPRIATE:

SINGLE EVENT CONSENT

I hereby acknowledge and agree to the conditions set forth below, to provide the medical information requested and to authorize_____to attend
(Name of student)
_____on _____.
(Event) (Date)

MULTIPLE EVENT CONSENT

I hereby acknowledge and agree to the conditions set forth below, to provide the medical information requested and to authorize_____to attend
(Name of student)
various events occurring from September 1, 20__ to August 31, 20___ .

PLEASE NOTE: Overnight events require an additional parental consent form.
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It is my understanding that the Immanuel Church of the Christian and Missionary Alliance, will exercise reasonably acceptable safety and health standards and will attempt to notify me in the event of any emergency such as would require a physician's attention. I do not hold the Immanuel Church of the Christian and Missionary Alliance, or any of its employees, officers, agents, or representatives responsible for the health and safety of my child, but do expect them to exercise all reasonable efforts to assure his/her well being. I further certify that to the best of my knowledge my child has not been exposed to any contagious diseases within the last thirty days. You have my permission to have a physician or surgeon attend to my child, to the extent necessary to protect and preserve the health of my child, including, but not limited to, performance of surgery deemed necessary and not elective. I further give my permission for the leaders/adults of Immanuel Church on this event to administer medications in the manner as stated below.

MEDICAL INFORMATION

Is your child allergic to:

____ bee sting ____ pollens ____ other drugs _____

____ hay, straw ____ penicillin ____ other _____

Does your child have any life-threatening allergies: ____ Yes ____ No If yes, to what?

_____

_____

Child's Physician: _____

City: _____ Phone: _____

Medications (Over-The-Counter): _____

Administered according to standard dosage instructions. _____ (Parent initials)

Medications (Prescription):

Name of Medication:_____ Dose: _____ Time: _____ Name of Medi

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If only specific individuals are permitted to administer the medication, please list their names.

_____

PLEASE NOTE: Medication should be in its original prescription bottle/package, which should have administration instructions and the child's name clearly indicated.

Does your child have any physical, emotional, mental or behavioral concerns or limitations that our staff should be aware of? ____ Yes ____ No If yes, please explain:

_____

_____

Has your child ever had:

____ seizures ____ asthma ____ diabetes

____ homesickness ____ heart disease ____ other _____

Date of last tetanus shot: _____

Parents will be notified immediately of any medical emergency.

Signature of Parent/Guardian: _____ Date: _____