

Inside Out Student Ministries

Child Care Contact/Medical Information



To be used Feb. 5th only – All information will be disposed of properly after this event.

Please print in ink

Name: _____ Age: _____
LAST FIRST (NICKNAME)

Name: _____ Age: _____
LAST FIRST (NICKNAME)

Name: _____ Age: _____
LAST FIRST (NICKNAME)

Name: _____ Age: _____
LAST FIRST (NICKNAME)

Address _____ City _____ State _____ Zip _____

Emergency Contact: _____ Emergency Phone # (Home/Work/Cell): _____
Please circle one

Mother's name: _____ Home Phone #: _____ Cell Phone #: _____

Father's name: _____ Home Phone #: _____ Cell Phone #: _____

Physician _____ Office Phone #: _____

Dentist _____ Office Phone #: _____

Please be sure to pack a dinner for your child(ren).

Medical

Check the following areas of concern for your child(ren). If necessary, add another page with details:

- Does your child have allergies to...
 pollens medications food insect bites
- Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:
 asthma epilepsy / seizure disorder heart trouble diabetes
 frequently upset stomach physical handicap
- Should this child's activities be restricted for any reason? Please explain:

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.

I/We the undersigned have legal custody of the child(ren) named above, a minor, and have given our consent for him/her to attend events being organized by the Church. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider.

Parent/Guardian signature: _____ Date: _____

PLEASE RETURN COMPLETED FORM TO EVELYN IN THE FIRST CHURCH OFFICE ASAP! THANK YOU!