Peace Fellowship Youth Events
PARENTAL CONSENT/MEDICAL RELEASE FORM

Name ______________________________________ Age ________ Birthdate: ____/_____/______

Address ____

Phone ____
Home Cell (parent/guardian 1) Cell (parent/guardian 2) Cell (student)

Grade in School ____________ School ____

The undersigned does herby give permission from our (my) child,

____ To attend and participate in youth activity

____ sponsored by Peace Fellowship Church.

We authorize an adult, in whose care the minor has been entrusted, to consent to any x-ray, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care to be rendered to the minor under the general or special supervision and 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.

We 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 of the project/event sponsored by Peace Fellowship Church.

Hospital Insurance: Yes ☐ No ☐

Insurance Company Name, Address & Phone:

Group, Policy Number, Etc.:

Emergency Phone Numbers:

_______________________________ / /
Participant Date

_______________________________ / /
Legal Guardian 1 Date

_______________________________ / /
Legal Guardian 2 Date

Please list any allergies or special medical conditions your child may have: