PARENT PERMISSION/RELEASE – CULLOWHEE BAPTIST CHURCH

_____ has my permission to participate in Cullowhee Baptist Church's children and youth program from_____, 2016 to December 31, 2016.

I understand that there are certain inherent dangers that exist in the activities that are provided during the program. Students will be transported to and from various activities by van. Students will participate in a variety of group activities and games that will be held outdoors. Injuries can occur from numerous methods and can result in: cuts, scrapes, burns, contusions, avulsions, factures, concussions, and even paralysis or death. I also authorize the use of my/my student's photograph in the publications related to the promotion of the church program.

EMERGENCY CONTACT FORM - CULLOWHEE BAPTIST CHURCH

(Please print)

Child's Name: _____
Age:_____ Date of Birth (mm dd yyyy):_____
Parent(s) or Legal Guardian:_____
Address:_____
Home Phone:_____ Cell Phone: _____
Father's Work Phone:_____ Mother's Work Phone:_____ Guardian's Work Phone:_____
Emergency Contact Person:_____ Phone: _____
Other Important Information:_____
_____

MEDICAL INFORMATION – CULLOWHEE BAPTIST CHURCH

Please complete the following medical information as thoroughly as you can. This will enable the church to better administer to your child's needs. *NO ORAL MEDICATION WILL BE GIVEN WITHOUT WRITTEN PERMISSION.*

1. The following may be given by a church leader if deemed necessary to relieve minor pain and discomfort.
   - Tylenol YES____ NO ____
   - Ibuprofen YES____ NO ____
   - Antacid for indigestion YES____ NO ____
   - Pepto-Bismol YES____ NO ____
   - Cough drops or throat lozenges YES____ NO ____
   - No medication should be given due to my convictions ____

2. Does your child have any problems with allergies, hay fever, asthma, or bed wetting?
   YES____ NO ____ IF YES please explain:_____
   _____
3. Does your child have any medical or physical condition which may limit your child's participation in church activities?
   YES____ NO ____ IF YES please explain:_____
   _____
4. Date of child's last tetanus booster:_____
5. Has your child evidenced an adverse allergic reaction to bee or wasp stings; or is he/she predisposed due to family medical history. YES____ NO ____ IF YES please explain:_____
   _____
6. If medication is to be given for any reason, please fill out the following:
   Type of medication:_____
   Dosage:_____
   Time given:_____ Reason for medication:_____
   _____
7. Insurance Co.:_____ Policy#:_____
   Child's Doctor:_____ Doctor's Phone:_____

I, _____ parent/guardian for _____ hereby authorize a medical doctor, nurse, or other trained provider to administer required medical attention to my child should an emergency occur.

All information contained herein is accurate and complete:
Signature Parent/Guardian: _____ Date: _____