

Morningside Baptist Church

1560 Pedrick Road, Tallahassee, Florida 32317

Permission/Consent Form

I, (we) _____ the parent(s) or guardian(s) of
(Name of parent or guardian on above line)

_____ understand that sickness and/or
(Name of youth on above line)

accidents may occur while he/she is participating in activities sponsored by Morningside Baptist Church of Tallahassee. I realize that accidents, injury and sickness may occur during (but not limited to) routine or recreational activity, supervised or unsupervised activity and that in such cases a representative of the church will notify me of the situation as soon as possible. I understand that this notification will be secondary to the security of the group and welfare of my child.

In the event my child experiences sickness or accident, I hereby grant permission to Morningside Baptist Church and/or representative(s) to seek medical and/or dental care as deemed necessary by the adult acting on behalf of the ministry at the time of need. I also grant permission for my child to be examined and treated as deemed necessary by any physician, surgeon, dentist, emergency medical personnel, nurse or others appropriately licensed for such treatment.

I further understand that while Morningside Baptist church carries accident insurance coverage, I must first apply for benefits available through personal hospitalization and medical coverage before applying for benefits that may be available through the ministry's coverage. I understand that any personal coverage available to the participant will be the primary provider and the ministry's coverage will be secondary.

I also understand that treatment and care for my child may include but not limited to: Hospitalization, walk-in clinic care, X-rays, injections, anesthesia, prescribed medication, over-the-counter medicine, ambulance transport or emergency medical rescue. In the event that medical and/or dental treatment is needed, I agree to reimburse Morningside Baptist Church for any expenses the church incurs while seeking treatment for my child. I understand that these expenses may include but are not limited to: Ambulance service, doctors' fees, prescription drugs, over-the-counter medication, lodging due to illness, emergency room fees, walk-in-clinic charges, long distance phone calls or transportation costs.

Every reasonable effort will be made to settle disciplinary problems in an accountable, productive and affirming manner. In the event, however, that my son/daughter impedes the direction and/or purpose of the event by his/her behavior and is sent home, it is my obligation to pay for all costs related to his/her return. I also understand that an attempt will be made to notify me prior to any early departure and that reasonable effort will be taken to ensure a safe early return.

_____ Date: _____
(Adult signature)

NOTARY

STATE OF _____ COUNTY OF _____

This instrument was acknowledged before me on _____

(Signature of Notary)

Morningside Baptist church

1560 Pedrick Road, Tallahassee, Florida 32317

Medical Information Form

(Please print or type all information)

Date ___/___/___

1. Name of Youth _____ D.O.B. _____
S.S.# _____

2. Address _____ zip _____ Ph# _____

3. Parent's (Guardian's) Name _____
Business Phone _____ Cell Phone _____
Father/Mother place of business _____

4. Family member or friend to be contacted if parents cannot be reached:
Name _____ Relationship _____ Ph# _____

5. Name of Physician _____ Ph# _____

6. Is your child currently covered by health insurance? Yes _____ No _____

Name of Company _____ Policy# _____
7. Does your child have a chronic illness ? Yes _____ No _____

If yes, explain _____
8. Allergies? Yes _____ No _____ If yes, explain _____

9. Allergic reaction to medication? Yes _____ No _____ If yes, give name(s) of medications _____

10. Any physical restrictions which limit activity? Yes _____ No _____ If yes, explain _____

11. Any adverse reactions to anesthesia? Yes _____ No _____ If yes, explain _____

12. Any history of seizures? Yes _____ No _____ If yes, how often and what kind? _____

13. Are you presently taking any medication? Yes _____ No _____ If yes, what kind(s)? _____

(All medication taken by your child must be described in writing, including name of medicine, dosage amount, how
And when it is to be administered, and must be given to the assigned minister prior to departure.)

14. Any history of diabetes? Yes _____ No _____ If yes, explain _____

15. Date of last tetanus shot _____

16. Other helpful Information _____