Parental Consent Form/Liability Release

Date ____
Child's Name _______________________________________ Age _______ Birthdate _______________
Address ____
City __________________________________ State ________ Zip Code ____________________________
Home Phone # ____________________________ Current Grade (or last completed) ________________

Parent's Cell Phone # (_____)_______________________ Work Phone # (_____)__________________
Emergency Contact # (____)_______________________ Name ___________________________________
Alternate Contact # (____)________________________ Name ___________________________________

PARENTAL CONSENT:

As parent/guardian of ____ I hereby give my permission for my child or ward to attend and participate in the activities sponsored by Lebanon Valley Youth For Christ (LVYFC). I do hereby hold harmless LVYFC, its Directors, Officers, Employees, Volunteers, or Agents of said organization, for any bodily injury, illness or disease, or for loss or damage to any property or appliance of said child or ward. I assume the risk and financial responsibility for any injury or liability resulting from his/her participation.

In case of a medical emergency, I understand every reasonable effort will be made to contact me. In the event I cannot be reached, I hereby give permission to secure proper treatment for, and order injection or anesthesia or surgery for my child or ward as named above. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to him/her.

The undersigned does also hereby give permission for said child or ward to ride in any vehicle designated by the staff of LVYFC while attending or participating in activities sponsored by LVYFC.

I consent to the use of any video images, photographs, audio recordings, or any other visual or audio reproduction that may be taken of said child or ward while participating in activities sponsored by LVYFC, to be used, distributed, or shown as LVYFC sees fit.

Student Signature (if over 18) ____

Print Name ____ Date __________________________

Parent/Guardian Signature (if child is under 18) ____

Print Name ____ Date __________________________

Please complete and sign the reverse side of this form.

(Office use: Program Director, file this form in your files.)

Revised February 2009

Medical Form

Name ____ Birthdate __________________

Check Boxes That Apply:

Allergies

- ☐ Food ____
- ☐ Peanuts
- ☐ Other ____
- ☐ Seasonal ____
- ☐ Aspirin
- ☐ Penicillin
- ☐ Other Drugs ____

Illnesses

- ☐ Heart Condition
- ☐ Convulsions/Seizures
- ☐ High Blood Pressure
- ☐ Fainting
- ☐ Frequent Upset Stomach
- ☐ Asthma
- ☐ Migraine Headaches
- ☐ Other ____

Are there any routine treatments or medications needed by your child on a daily basis?

- ☐ No
- ☐ Yes If yes please list____
- ☐ The child can take their medication on their own.
- ☐ The child must have this administered by an adult.

Insurance Information

Does the child have medical insurance?

- ☐ No
- ☐ Yes

Insurance Company____

Insurance Policy #____

Parent or Guardian Signature_____________________________________ **Date**__________________

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