

(To be completed by activity leader)

Nature of activity: _____

Beginning date & time: ____:____AM/PM___/___/___ Ending date & time: ____:____AM/PM___/___/___

Funds needed: \$_____ Other items needed: _____

Transportation Plans (Circle):Bus provided / Personal Vehicles / Volunteer drivers needed / None needed

Childs Name and Address

Name of child: _____ Date of birth: _____

Phone number: _____ Sex: _____ Height: _____ Weight: _____

Address: _____ T/Shirt Size _____ School Grade _____

Insurance and doctor information

Do you have health insurance? _____

Name of insurance company: _____

Policy number: _____ Group number: _____

Name listed on policy: _____ Insurance phone number: _____

Doctor's name: _____ Phone number: _____

City/state: _____

Health information

Please list current medication taken by minor and dosage: _____

Please list any known pre-existing conditions: _____

Please list all known allergies: _____

Date of last tetanus shot: _____

Does the child wear contact lenses? _____ Glasses? _____

List any known restrictions or other special physical or dietary needs: _____

Contact information

Parent/guardian contact: _____ Address: _____

[Home](____) _____ [cell](____) _____ [work] (____) _____

Backup contact: _____ Address: _____

[Home](____) _____ [cell](____) _____ [work] (____) _____

I, _____ (printed name of parent/guardian) being the parent or legal guardian of _____ (printed name of minor) have been informed of the above activity sponsored by Conyers Church of Christ and hereby give my consent for my minor child to participate in this activity. I understand that all reasonable safety precautions will be taken by the leaders of this activity, and that the possibility of an unforeseen hazard does exist.

Being the parent or legal guardian of _____ (printed name of minor), I _____ (printed name of parent/guardian) do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child. Any policy of the church or organization sponsoring this even will be used as secondary coverage.

Minor's date of birth: _____

Signature of parent/guardian: _____ Date signed: _____