Youth Permission Slip/Medical Release Form

Please Print

Circle one

Youth's Name_____ Male/Female

Date of birth_____ What Grade for school yr. 2011-2012 ____

Parent'(s) Name(s)_____

Guardian(s) name(s) _____

Address: _____

City: _____ Zip: _____

Home Phone: (___) _____ - _____ Work Phone: (___) _____ - _____

Cell Phone: (___) _____ - _____

Emergency Contact Name and Phone:

_____ (___) _____ - _____

I/We hereby give my/our permission for my/our child _____ to attend the Calvary Chapel La Mirada sponsored Youth Ministry events during the next 12 months beginning the month of June/2011 to the end of June/2012. I/We understand that there will be adult supervision at these events. I/We also understand that if there are any disciplinary problems with the above named child, it will be our responsibility to pick up our child at the site of the above event and they will not be eligible for future events without specific approval of the Calvary Chapel La Mirada leadership.

AUTHORIZATION TO CONSENT TO TREATMENT

I/We, the undersigned, parent(s)/Guardian(s) of the child named above on this consent form, do hereby authorize Calvary Chapel La Mirada, it's staff or representatives, as agent(s) for the undersigned to consent to a X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care that is deemed advisable by, and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the Medical Staff of any Hospital or medical clinic whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment of hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

The authorization is given pursuant to the provisions of **Section 25.8 of the Civil Code of California** (allows Parent(s) or Guardian(s) to authorize any adult to consent to medical or dental treatment as stated in the above paragraphs).

This authorization shall remain **effective from June 24, 2011 through June 29, 2012,** unless sooner revoked in writing delivered to said agent(s)

Dated:

_____Sign_____

Parent or Legal Guardian

Health History

To protect your child from possible embarrassment, but not to exclude him/her from the program, the following information is requested. Check and give approximate dates if possible:

General:

Frequent Ear Infections
_____

Bleeding/Clotting Disorders
_____

Bed Wetting
_____

Operations or Serious Injuries
_____

Heart Defect/Disease
_____

Convulsions/Diabetes
_____

Insect Stings
_____

Sleep Walking
_____

Hay Fever
_____

Penicillin
_____

Other Drugs (List)
_____

Diseases:
Chicken Pox
_____

Measles
_____

German Measles
_____

Mumps
_____

Asthma
_____

Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity?

Yes _____ No _____ If yes, explain:

_____

Please give us the name, address and phone number of your child's regular physician:

_____

In the event of a minor illness (such as cold or headache), do you authorize the Leadership of Calvary Chapel La Mirada to give your child common remedies such as Tylenol, cough medicine, etc., in dosages appropriate for his/her age?

Yes ____ No ____ Please list any specific instructions:

_____

Please list any medications that your child will need to be taking on any camps or overnight youth events:

MEDICATION: **DOSAGE:** **WHEN TAKEN:**

_____

_____

Insurance Information

Insurance Company Name, Address, Phone no:

_____

Policy Number: _____ Name of Primary Insured: _____