Parental Consent & Medical Release Form

Duplain Church of Christ
5565 East Colony Road ● St. Johns, Michigan ● 48879
Phone: (989) 224-4878

To whom it may concern: *Please fill out completely!!!*

The undersigned does hereby give permission for our/my child(ren) listed below to attend and participate in the **CIY Mover June 26-July1st 20017** which is a planned activity of the Duplain Church of Christ. In case of an emergency, I hereby request and give my full consent for medical care, treatment and/or surgery, and authorize admission to an area hospital as the treating physician may deem medically necessary, for my child(ren) during the activity listed above. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical services rendered to the child(ren) listed below pursuant to this authorization. Should it be necessary for our child(ren) to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs. The undersigned does also hereby give permission for our child(ren) to ride in any vehicle designated by the current youth sponsor(s) in whose care the minor has been entrusted while attending and participating in activities sponsored by the Duplain Church of Christ.

List the name(s) and medical information of child(ren) attending and participating in above listed event. Be as complete as possible. (Use the back of this form if necessary).

Name	Age	Allergies	Current Medications	Special Medical Problems
1.				
2.				
3.				

List all adults living with child(ren) listed above and their relationship to him(her).

Name	Relationship	Phone (where can be reached)
1.		
2.		
3.		

Other relatives or people to contact in an emergency if parent or guardian can't be reached:

Name	Relationship	Phone (where can be reached)
My child(ren) wil 1.		
2.		

My child(ren) will be in the care of: Duplain Church of Christ (address & phone listed above).

Signature of parent or guardian: _____ Date: ____/____/____

Address/city/state/zip: _____

Home phone: (_____) _____ Work phone if at work during activity: (_____) _____

Medical Insurance Company: _____ Policy #: _____

Doctor's Name: _____ Office Phone #: _____