

SPRING MOUNT MENNONITE CHURCH

25 Church Road, Schwenksville, PA 19473
springmountmc@gmail.com

PARENTAL CONSENT FOR PARTICIPATION IN ALL CHILDREN & YOUTH ACTIVITIES AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Youth's Name: _____

Full Address: _____

Phone: _____ Parents Work # (Mom) _____ (Dad) _____

Parents Cell # (Mom) _____ (Dad) _____

In Case of Emergency Notify: _____ Phone: _____

Family Doctor: _____ Phone: _____

Insurance Company: _____ Policy #: _____

I DO / DO NOT (Circle one) give permission to post pictures with my child included on the church website (www.springmountmennonite.org)

PHYSICAL CONDITION

Are there any activity restrictions?: Yes ____ No ____ (please give details on back of this form)

Also, on the reverse side, please list any allergies or medical problems/conditions your child may have.

Is there any medication that we need to be aware of (list if necessary)?: _____

I/We _____, the parent(s) (or legal guardian) of the above named child, hereby give my/our consent to youth participation in the scheduled youth activities. I/we assume all risks and hazards incident to such participation including transportation to and from the activity and I/we hereby waive, release, absolve, indemnify and agree to hold harmless SPRING MOUNT MENNONITE CHURCH sponsors, supervisors, organizers, and persons transporting my/our child to or from such activity, for any claims out of an injury to my/our child, except to the extent and in the amount covered by accident or liability insurance.

I/We the undersigned, parent(s) (or legal guardian) of _____, a MINOR, do hereby authorize the church leader for the undersigned to consent to any X-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, 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 and 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 or hospital care which the aforementioned physician in the exercise of his /her best judgment may deem advisable.

I know of no health reason why my son/daughter may not participate in any Youth activities.

SIGNATURE: _____ DATE: _____