PARENTAL CONSENT AND MEDICAL AUTHORIZATION

JupiterFIRST CHURCH

Today's Date:_____

Name of Parent or Legal Guardian: _____

Address: _____
Street/Apt Number City Zip code

Daytime Phone Number: _____ Evening Phone Number: _____

Email Address: _____

Name of child/youth: _____ Date of Birth:_____

I _____ (name of parent or guardian) understand that my child/youth will be participating in a number of activities which carry with them a certain degree of risk. Some of the activities are swimming, boating, hiking, camping, field trips, sports and other activities which the church may offer. I consent for my child to participate in these activities.

Please indicate any restrictions on your child's/youth's activities:

_____I represent that my child/youth is physically fit and has the necessary skills to safely participate in these activities.

_____I represent that my child/youth has restrictions on the following particular activities:_____

_____

_____I also understand and give consent for my child to travel to and from these events in transportation provided by volunteer drivers.

MEDICAL TREATMENT AUTHORIZATION: It is my understanding that the Church will attempt to notify me in care of a medical emergency involving my child/youth. If the church cannot reach me, then I authorize the church to hire a doctor or health-care professional, and I give my permission to the doctor or other health-care professional, to provide the medical services he or she may deem necessary. I will pay for any medical expenses so incurred.

I will notify the church if I feel there are any health considerations that would prevent my child/youth's participation in any of the activities listed above.

Allergies or other health considerations: _____

PLEASE ATTACH A COPY (FRONT AND BACK) OF CHILD'S/YOUTH'S INSURANCE CARD
PLEASE CHECK HERE ☐ IF YOU DO NOT CARRY HEALTH INSURANCE FOR YOUR CHILD/YOUTH.

MEDICATION: Please list any medications your child/youth takes regularly:

Medication Name	Dose	Frequency	Time Taken	Reason

Authorization for As Needed Medications: I give permission for any first aid staff or volunteer nurse to administer the following checked medications to my child/youth as necessary. If a symptom is recurring or a question exists about medication, I understand I will be contacted by phone to clarify the issue. All non-prescription medication label directions will be followed.

☐ Acetaminophen – fever, headache, pain	☐ Tums (Calcium Carbonate) – Upset stomach, heartburn
☐ Ibuprofen – fever, headache, pain	☐ Pepto Bismal (Bismuth Subsalicylate) – upset stomach, diarrhea
☐ Benadryl – poison ivy, bug bites, minor allergy	☐ Aloe – Sunburn
☐ Calamine Lotion – poison ivy, bug bites	☐ Cough Drops – cough or sore throat
☐ Benadryl Cream – poison ivy, bug bites, rashes	☐ Sore Throat Spray (Phenol 1.4%) – sore throat
☐ Hydrocortisone Cream – poison ivy, bug bites, rashes	

PHOTOS: All participants in programs that fall under JupiterFIRST Church will likely be photographed from one time to another. These photos may be placed in newsletters, marketing pieces, or other publications. Pictures may also be used for social media purposes, including but not limited to Facebook, Twitter, Instagram, program websites, and other similar outlets.

Person to contact other than parent/guardian in an emergency:

Name _____ Phone # _____

Email Address: _____

PLEASE SIGN IN THE PRESENCE OF A NOTARY:

Print Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

The foregoing instrument was acknowledged before me this ____day of _____ 20___by (Name of Affiant) _____who is __ personally known to me or who has ___ produced _____ as identification. (write/type of identification and identification number.)

_____
Signature of notary

Notary Seal