

PERMISSION AND MEDICAL CONSENT

As parent or legal guardian, I hereby give permission for my child to participate in all "Open Gym" activities in The ROC (Recreational Outreach Center) of Wake Cross Roads Baptist Church

Child's Full Name _____
Last First Middle

Sex _____ Birthday _____ Age _____

Parent or Guardian Name _____

Home Address _____

Home Phone _____ Business Phone _____

Does this child have any of the following allergies :

Penicillin _____ Other : _____

Other Drugs _____

Insect Stings _____

Ivy Poisoning, etc. _____

Hay Fever _____

Does this child have any medical or health problems, and has this child had any chronic or recurring illness or illnesses, which would have an effect on the child's participation in Recreational Activity? Yes No

If yes, describe the problems or illnesses _____

State the name, address, medical specialty and phone number of this child's family physician and of any other physician who should be consulted in the event of emergency or medical problems involving this child :

State the name, address, and phone number of this child's dentist (and orthodontist if applicable) :

Is there medical or hospitalization insurance which provides benefits for this child? _____ If so, please indicate:

Name of Insurance Co. _____

Address _____

Policy No. of Insurance Policy _____

Name of Policy Holder _____

Phone No. of Insurance Co. (_____) _____

Is this child on any medications? _____ If so, please state the medication : _____

Other comments or suggestions from the parent or guardian concerning this child _____

I understand that, in the event my child requires medical or dental treatment while engaged in activity at the Roc, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the ministry's sponsor or any adult counsellor acting on behalf of the ministry with respect to the Activity, as agent for me, to consent to any X-ray examination; injections; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medications being taken, medical problems and other pertinent information. My child has permission to participate in all prescribed activities except as noted by me.

Signature _____ Date _____
(Individual, Parent or Guardian)

Print Full Name _____ Date _____