



2024 Annual

Parental Consent, Certification, and Medical Authorization

PLEASE ATTACH A COPY OF MEDICAL INSURANCE CARD

Child's Name: _____ Date of Birth: _____

Father: _____ Mother: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell: _____ Cell: _____

Email: _____ Email: _____

Doctor's Name: _____ Telephone: _____

Insured Name: _____ Carrier: _____ Policy #: _____

Known Allergies, Medical Conditions: _____

Medications or drugs taken regularly: _____

Please List Any OVER THE COUNTER Medications your child CANNOT take: _____

LOCAL relative or friend to notify in case of an emergency and we cannot locate parent:

Name: _____ Telephone: _____

Is your child/student presently being treated for an injury or sickness or taking any medication? YES [] NO []

If yes, please explain. _____

Does your child/student currently have or ever had the following: (Circle and explain below.)

- Asthma Hay fever Kidney disease Diabetes Heart murmur Seizure disorders Sleep Disorders Other

Please explain: _____

Child/Student blood type _____ (if known)

It is my understanding that the church will attempt to notify me in case of a medical emergency involving my child. If the church cannot reach me, I authorize the church to seek professional medical care for my child. I give my permission to the doctor or other health-care professional to provide necessary medical services. I will pay for any medical expenses incurred. I will notify the church if I feel there are any health considerations that would prevent my child's participation in an activity. I also give my permission for church leaders to restrict my child from participation in any activity which they have any question about for health or safety reasons.

If a dispute over this agreement or any claim for damages arises, the process for reporting and resolution as outlined in the North Shelby Baptist Church Child Protection Policy shall be followed.

Signature of Parent or Legal Guardian

Date