

## 2009-2010 FIRST (SCOTS) PRESBYTERIAN CHURCH PARENTAL RELEASE STATEMENT

Youth Name: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Youth Cell Phone: \_\_\_\_\_

City and Zip: \_\_\_\_\_ Grade/School: \_\_\_\_\_

Youth Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Parent Email: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Parent Email: \_\_\_\_\_

I grant permission for my above-named child to join the youth of First (Scots) Presbyterian Church on any retreat, trip, or youth activity scheduled and approved by the Christian Education Committee and/or Church Session for September 1, 2009 – September 30, 2010. I understand that the church follows the “Two Adult Rule” and provides adult to youth ratios of 1:7 for youth in the 6<sup>th</sup> – 12<sup>th</sup> grades. All co-ed retreats or overnight activities will be supervised by male and female chaperones.

I hereby release First (Scots) Presbyterian Church, its staff, and chaperones from any responsibility and liability for any injury or illness that my child may sustain during his or her participation with the youth group. In the event of an emergency, I hereby authorize an adult leader of the youth group, as agent for me, to consent to any x-ray examination; medical, dental, or surgical diagnosis; treatment; and hospital care 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 at a doctor’s office or in any hospital. I expect to be contacted as soon as possible. I further give permission for my child to take prescribed medication and I shall provide instructions for any questions that may arise concerning these medications.

**Signature of natural parent/legal guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name of Person Signing:** \_\_\_\_\_

1<sup>st</sup> Emergency phone number: \_\_\_\_\_ 2<sup>nd</sup> Emergency phone number: \_\_\_\_\_

### **A second contact person to notify in case of emergency:**

Name: \_\_\_\_\_ 1<sup>st</sup> phone number: \_\_\_\_\_

Relation to youth: \_\_\_\_\_ 2<sup>nd</sup> phone number: \_\_\_\_\_

### **Medical Information**

Allergies: \_\_\_\_\_

Medications being taken and dose: \_\_\_\_\_

Directions for medication and frequency: \_\_\_\_\_

Physical disabilities or limitations: \_\_\_\_\_

Medical insurance company: \_\_\_\_\_ Policy number: \_\_\_\_\_

Member’s name: \_\_\_\_\_ Employer: \_\_\_\_\_