

# COMMUNITY CHURCH PARENTAL/GUARDIAN CONSENT AND MEDICAL RELEASE FORM FOR STUDENT MINISTRY (6TH-12TH GRADE)

Please complete one form for each 6th-12th grade student and return to:

Community Church  
N6717 Streblow Drive  
Fond du Lac, WI 54937

## GENERAL INFORMATION (PLEASE PRINT)

Student's Name \_\_\_\_\_ Cell # \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

Mom's Name \_\_\_\_\_ Cell # \_\_\_\_\_ Mom's Work # \_\_\_\_\_

Dad's Name \_\_\_\_\_ Cell # \_\_\_\_\_ Dad's Work # \_\_\_\_\_

May we send text updates/reminders to the cell numbers listed above? \_\_\_\_\_ Preferred # \_\_\_\_\_

Home # \_\_\_\_\_ Family E-mail \_\_\_\_\_ I live with \_\_\_\_\_

Student's Address, City, State, & Zip \_\_\_\_\_

Family Doctor \_\_\_\_\_ Doctor's # \_\_\_\_\_

**CONSENT**  
I, being the parent or legal guardian of the student named above, do consent to the participation of the student in all of the scheduled activities of Community Church, Fond du Lac, WI, through August 2020. This includes field trips and any other activities customarily associated with a church group. I certify that the student is physically fit to participate in such events (except as noted below).

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

## MEDICAL INFORMATION

Is student presently being treated for an injury or sickness, or taking any form of medication for any reason?  
YES NO If yes, please explain:

Is student allergic to anything, including medication? YES NO If yes, please explain:

Does student require a special diet? YES NO If yes, please explain:

Does student have (or ever had) any of the following? (Circle and explain below)  
Seizure disorders Asthma Heart murmur Diabetes Hay fever Kidney disease

Does student have any physical handicap or illness which would prevent him/her from participating in normal rigorous activity?  
YES NO If yes, please explain:

Is there anything else we should know about your student's physical/medical condition?  
YES NO If yes, please explain:

## MEDICAL TREATMENT AUTHORIZATION

I understand that I will be notified in case of a medical emergency involving the above student. However, in the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services. I understand that Community Church will not be responsible for medical expenses incurred, and that such expenses will be my responsibility as parent/guardian. I agree to notify the church in the event of health changes which would restrict the student's participation in any normal activities. I also understand that the adult leaders reserve the right to restrict the student from any activity that they do not feel is within the physical capabilities of the student.

**PHOTO RELEASE:** I give Community Church permission to use photographs taken of my child for promotional purposes.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Medical Insurance Company: \_\_\_\_\_ Claim ID # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_