

Parental Consent Form

First Baptist Church Nevada, MO

Student's Name _____ Age _____ Birthday ___/___/___

Address _____ City _____ State _____ Zip _____

School _____ Grade _____ Phone (_____) _____ - _____

Parent or Guardian Name _____ Phone (_____) _____ - _____

Work Phone (_____) _____ - _____ Mobile Phone (_____) _____ - _____

Emergency Contact _____ Relation _____

Emer. Home Phone (_____) _____ - _____ Emer. Mobile or Work Phone (_____) _____ - _____

The undersigned do hereby give permission for our (my) child, _____, to attend and participate in activities sponsored by First Baptist Church of Nevada, Missouri.

We (I) authorize an adult in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by First Baptist Church of Nevada, Missouri.

Insurance Company _____ Policy # _____ Group # _____

Policy Holder's Name _____ Relation _____

Date of Birth ___/___/___ Employer _____ Insurance Phone (_____) _____ - _____

Physician's Name _____ Phone Number (_____) _____ - _____

List Any Allergies _____

List Any Medications _____

I give permission for my child to take over-the-counter medication if the need arises. _____ Yes _____ No

Date of Last Tetanus Shot ___/___/___ Describe any other medical conditions on the opposite side.

Parent or Guardian Signature _____ Date ___/___/___

Participant if 18 _____ Date ___/___/___

Please return with a copy of both sides of your insurance card. Thank you.