

**Parental Consent and Release Forms**  
**2009-2010 Student Ministries**  
**First Presbyterian Church of Dutch Neck Youth Ministry Programs**

Student: \_\_\_\_\_ Sex (circle): M F Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's email address: \_\_\_\_\_ Student's mobile phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Home Phone (if different than student's): \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Mother's email address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Home Phone (if different than student's): \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Father's email address: \_\_\_\_\_

In case of emergency, after attempting the above phone number(s), please contact:

Name: \_\_\_\_\_ Relation to student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Beeper or cell phone: \_\_\_\_\_

Does the student have any ALLERGIES or MEDICAL CONDITIONS that should be considered? (Circle one) YES NO

If you circled YES, please explain: \_\_\_\_\_

Is there any sort of activity that should be restricted? If so, please explain: \_\_\_\_\_

Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Do you have family medical / hospital insurance? (Please circle one): YES NO If YES, indicate:

Carrier: \_\_\_\_\_ Policy or Group #: \_\_\_\_\_

In the event that hospitalization is necessary, I prefer that my child be sent to \_\_\_\_\_ hospital.

**Student's Health History Checklist**

The answers to these questions are confidential, but will help us know if your child has any medical problems. We need this information in the event he / she should become ill and we are unable to reach you right away. Please circle YES or NO:

- YES NO 1) Has your child ever been hospitalized over night, had surgery or serious illness?  
 YES NO 2) Is your child taking any medication? If yes, please list medication (s):  
 \_\_\_\_\_  
 YES NO 3) Any allergies or reactions to medicine, DPT or other shots, insect bites?  
 \_\_\_\_\_  
 YES NO 4) Does your child have speech or hearing problems?  
 YES NO 5) Has your child had asthma or wheezing?  
 YES NO 6) Does your child have trouble with his / her eyes or seeing?  
 YES NO 7) Has your child had a bladder or kidney infection? Date: \_\_\_\_\_  
 YES NO 8) Does he / she have seizures, fits or shaking spells?  
 YES NO 9) Does your child have a heart murmur, a heart defect or heart disease?  
 YES NO 10) Is your child able to play as hard as other students?  
 YES NO 11) Has your child ever had a bumpy, swollen reaction to the TB skin test?

- YES NO 12) Has your child been with anyone having TB?  
 YES NO 13) Is your child a hemophiliac?  
 YES NO 14) Does your child have Hepatitis?  
 YES NO 15) Does your child have tubes in his / her ears?  
 YES NO 16) Does your child have a hernia?  
 YES NO 17) Does your child have a frequent ear infection?  
 YES NO 18) Does your child have diabetes?  
 YES NO 19) Does your child have hypertension?  
 YES NO 20) Does your child have dizzy spells or headaches?  
 YES NO 21) Does your child have skin problems?  
 YES NO 22) Has your child ever had broken bone(s), dislocated joints or serious sprains? Date: \_\_\_\_\_  
 YES NO 23) Does your child have a chronic or recurring illness?

Explain: \_\_\_\_\_  
 \_\_\_\_\_

When did your child have:  
 \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_ German Measles

When did your child last see a doctor? Month / Year: \_\_\_\_\_

My child's immunization records are on file at \_\_\_\_\_ school  
 and are up to date to the best of my knowledge.

General Development:  
 YES NO 1) Is your child in a special education class at school?  
 YES NO 2) Does your child have any problems not listed?  
 above? \_\_\_\_\_  
 \_\_\_\_\_

Is there any other information we should know about your child? (i.e. emotional problems, learning disabilities, life situation, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**2009-2010 Junior and Senior High Program Release Form**  
**First Presbyterian Church of Dutch Neck / 154 South Mill Road, Princeton Junction, New Jersey 08550.**

I give permission for my child(ren), \_\_\_\_\_  
 to participate in all First Presbyterian Church of Dutch Neck Youth Group activities for the 2009-2010 program year, including field trips and transportation where applicable. I acknowledge that this may include potentially dangerous activities (i.e. physical games,

rafting, rock climbing, hiking, skiing, etc.) but understand that every precaution will be taken by the church staff, chaperones and instructors to insure the safety and responsible behavior of each participant.

The health history provided is correct as far as I know, and my child named above has permission to engage in all activities except as noted\*. In the event I cannot be reached in an emergency, I hereby give permission to the First Presbyterian Church of Dutch Neck's staff or chaperones, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical treatment (including 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. In addition, I understand that I will be responsible for any costs incurred in connection with such medical services rendered to the aforementioned child pursuant to this authorization.

In the unlikely event an accident should occur, I agree to hold First Presbyterian Church of Dutch Neck as well as its staff persons, chaperones, and volunteer leaders harmless from any liability due to the injury of my child. Should it become necessary for the church staff, chaperones or volunteers to give medical consent for our family, we agree to hold such individual and First Presbyterian Church of Dutch Neck free and harmless of any claims, demands or suits for damages arising from the giving of such consent as long as the treatment is administered by or under the supervision of a licensed physician.

Yes, I agree to the above: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent / Legal Guardian)

Insurance carrier: \_\_\_\_\_ Policy or group #: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Physician's name and phone number: \_\_\_\_\_

Emergency contact other than custodial parent: \_\_\_\_\_

\* Please note any specific activities in which your child is unable to participate: \_\_\_\_\_

\_\_\_\_\_