

# COMPREHENSIVE PERMISSION, MEDICAL RELEASE, TREATMENT AUTHORIZATION AND RELEASE FORM

Please legibly print the following information about your child.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

Child's Primary Residence Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Contact Information for Mother

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Home Address of Mother: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Contact Information for Father

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Home Address of Father: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Additional Emergency Contact Person If Neither Of Above Can Be Reached:

Name \_\_\_\_\_ Relationship of this person to child: \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

*(If being completed by a Guardian rather than Parent(s) please supply a copy of your certified guardian authorization document.)*

## Child's Medical History

Please provide in detail any and all information of which our staff and volunteers should be made aware to be able to properly provide a safe and healthy environment for your child. Please attach any additional information to this form you feel important for us to know including but not limited to medications and dosage amounts for your child and the timing of such dosages. Celebration Church will exercise normal care to maintain the confidentiality of this information. Some of the activities in which your child may participate may be physically strenuous. Please attach any additional information regarding the specific types of physical activities you DO NOT want your child participating in.

1. Is your child in good health and able to participate in normal activities?  Yes  No  
*(If No, please provide us with the specific limitations or restrictions for your child by an attachment.)*
2. Date of last tetanus shot: \_\_\_\_\_
3. Does your child have any allergies?  Yes  No If Yes, please list: \_\_\_\_\_  
*Please attach any other allergy information we or medical personnel should know.*
4. Will your child have in his/her possession an Epipen?  Yes  No.
5. Does your child suffer from or been recently treated for any of the following:  
 Asthma  Diabetes  Depression  Epilepsy/Seizure Disorder  Frequent upset stomach  
 Motion Sickness  Heart trouble  Physical handicap Other: \_\_\_\_\_
6. Does your child have a medically restricted diet?  Yes  No  
*If so, please attach information to guide us.*
7. Is your child a capable swimmer?  Yes  No
8. Is there any other information we need to know in order to help care for or to seek treatment for your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Name and contact information for your child's primary care physician:  
Name \_\_\_\_\_ Phone: \_\_\_\_\_

## MEDICAL TREATMENT AUTHORIZATION

**Emergency Medical Treatment:** In the event of an emergency involving my child, I hereby give permission to transport my child to a hospital or clinic for emergency medical or surgical treatment at my expense. I request to be advised at the earliest time of the incident and consulted prior to any further treatment that may be necessary. In the event you are unable to reach me, such treatment may be administered as deemed necessary by the medical personnel.

Approved: Initials of Parent(s) or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Medications:** My child is currently taking medications. My child will bring all necessary medications which will be clearly labeled in original packaging. I/we will supply written instructions with the medications as to which medications are to be taken when and in what dosage and with food or not so that personnel can see that they are properly taken.

Approved: Initials of Parent(s) or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### Select ONE of the following statements:

- No medications of any type, whether prescription or not may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Approved: Initials of Parent(s) or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### OR

- I hereby grant permission for non-prescription medications (such as acetaminophen or ibuprofen or naproxen sodium (Aleve), throat lozenges, cough syrup, etc...) to be given to my child if deemed appropriate.

Approved: Initials of Parent(s) or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## PERMISSION OF PHOTO/VIDEO

I grant permission to Celebration Church, Blountville, TN, its staff, employees, volunteers or representatives, to take and use the following regarding my child for ministry purposes:

(Check all that apply)

- photographs/digital images     videotape

## PERMISSION TO TRANSPORT MY CHILD AND RELEASE OF LIABILITY FORM

We, the undersigned hereby give consent to Celebration Church staff and volunteers to transport my/our children.

We further release and hold harmless Celebration Church its staff, Ministers, employees, Delegates, volunteers, officers, directors, entity and Elders from any liability or claim of liability, including negligence for any personal injury in any manner arising from said transportation or the activities of the event.

**I have read this entire release and permission form and fully understand its content and agree to be legally bound by it.**

Father/Guardian: \_\_\_\_\_ Mother/Guardian: \_\_\_\_\_

Print name \_\_\_\_\_ Print name \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE ATTACH COPIES OF ALL REQUESTED INFORMATION AS SET FORTH ABOVE**