1560 Pedrick Road
Tallahassee, Florida 32317

Permission/Consent Form

I, (we) ____the parent(s) or guardian(s) of
(Name of parent or guardian on above line)

____understand that sickness and/or accidents may occur
(Name of youth on above line)

while he/she is participating in activities sponsored by Morningside Baptist Church of Tallahassee. I realize that accidents, injury and sickness may occur during (but not limited to) routine or recreational activity, supervised or unsupervised activity and that, in such cases, a representative of the church will notify me of the situation as soon as possible. I understand that this notification will be secondary to the security of the group and welfare of my child.

In the event my child experiences sickness or accident, I hereby grant permission to Morningside Baptist Church and/or representative(s) to seek medical and/or dental care as deemed necessary by the adult acting on behalf of the ministry at the time of need. I also grant permission for my child to be examined and treated as deemed necessary by any physician, surgeon, dentist, emergency medical personnel, nurse or others appropriately licensed for such treatment.

I further understand that while Morningside Baptist Church carries accident insurance coverage, I must first apply for benefits available through personal hospitalization and medical coverage before applying for benefits that may be available through the ministry's coverage. I understand that any personal coverage available to the participant will be the primary provider and the ministry's coverage will be secondary.

I also understand that treatment and care for my child may include but not limited to: hospitalization, walk-in clinic care, X-rays, injections, anesthesia, prescribed medication, over-the-counter medicine, ambulance transport or emergency medical rescue. In the event that medical and/or dental treatment is needed, I agree to reimburse Morningside Baptist Church for any expenses the church incurs while seeking treatment for my child. I understand that these expenses may include but are not limited to: ambulance service, doctor's fees, prescription drugs, over-the-counter medication, lodging due to illness, emergency room fees, walk-in-clinic charges, long distance phone calls or transportation costs.

Every reasonable effort will be made to settle disciplinary problems in an accountable, productive and affirming manner. In the event, however, that my son/daughter impedes the direction and/or purpose of the event by his/her behavior and is sent home, it is my obligation to pay for all costs related to his/her return. I also understand that an attempt will be made to notify me prior to any early departure and that reasonable effort will be taken to ensure a safe early return.

Signature: ____ Date: _____________________
(Parent/Guardian)

NOTARY

STATE OF __________________________________ COUNTY OF ________________________

This instrument was acknowledged before me on ____

____
(Signature and Stamp of Notary)

1560 Pedrick Road
Tallahassee, Florida 32317

Medical Information Form

(Please print or type all information) Date ______/______/______

1. Name of Youth: ________________________________ DOB: ____________________
2. Address: ____________________________________ Phone: ____________________
3. Parent (Guardian) Name: ____
4. Emergency contact person if parents cannot be reached:

   Name: ____

   Relationship: ____________________________ Phone: _________________________
5. Name of Physician: ____________________________ Phone: ____________________
6. Is your child currently covered by health insurance? Yes _______ No _______

   Name of Company: ____________________________ Policy #: ____________________
7. Does your child have a chronic illness? Yes _______ No _______

   If yes, explain: ____
8. Allergies? Yes _______ No _______

   If yes, explain: ____
9. Allergic reaction to medication? Yes _______ No _______

   If yes, give name(s) of medication: ____
10. Any physical restrictions which limit activity? Yes _______ No _______

    If yes, explain: ____
11. Any adverse reactions to anesthesia? Yes _______ No _______

    If yes, explain: ____
12. Any history of seizures? Yes _______ No _______

    If yes, explain: ____
13. Are you presently taking any medication? Yes _______ No _______

    If yes, what medication(s): ____
    (All medication taken by your child must be described in writing, including name of medicine, dosage amount, how and when it is to be administered and must be given to the assigned minister prior to departure.)
14. Any history of diabetes? Yes _______ No _______

    If yes, explain: ____
15. Date of last tetanus shot: ______/______/______
16. Other helpful information: ____