

FIRST CHRISTIAN CHURCH OF HAGERSTOWN, MARYLAND
RELEASE AND CONSENT FORM FOR CHILDREN/YOUTH MINISTRIES 2024/2025 PROGRAM YEAR ACTIVITIES

Students Name: _____ Age: _____ Date of Birth: ____/____/____
Address: _____ City: _____ State: _____ ZIP: _____
Home Phone: () _____ Cell Phone: () _____
Student's E-mail: _____ Grade: _____ School: _____
Parent/Guardian Name: _____ Cell Phone Number: _____
Parent's E-mail: _____ Preferred Method of Contact: _____
Parent/Guardian Name: _____ Cell Phone Number: _____
Parent's E-mail: _____ Preferred Method of Contact: _____

_____ has my / our permission to participate in any youth or children's ministry sponsored activities for the 2024/2025 program year which coincides with the SUMMER PRIOR to and the 2023/2024 school year.

Does the child/youth swim? Yes _____ No _____

I/We also give consent for _____'s picture to be taken and used for any promotional and/or publication purposes of First Christian Church of Hagerstown or related organization, along with or in conjunction with Facebook.

Any pertinent information concerning any limitations (physical, mental, emotional) that would affect the child's/youth's participation in the program activities? Please explain in detail:

STUDENT'S HOSPITALIZATION COVERAGE: (If possible, please attach copies of any insurance/prescription cards)

NAME AND ADDRESS OF INSURANCE COMPANY _____

NAME AND ADDRESS OF INSURED _____

POLICY NUMBER _____ GROUP NUMBER _____

RELATIONSHIP TO STUDENT _____

EMPLOYER NAME AND ADDRESS _____

Date Form Filled Out: _____ (effective through May 2025) (C/Y CONS FORM May 2024)

HEALTH HISTORY: (please give dates where known)

Operation (with in the last year) _____

Allergy (bee stings, food) _____

Asthma _____

Diabetes _____

Emotional Problems (panic attacks) _____

Epilepsy _____

Medical Condition _____

Tetanus-last injection _____

Any special health problems in past? _____

Allergy to Drugs- (specify i.e. Penicillin, Insulin, etc...) _____

Any Medications Student is on: include anti-convulsive, antihistamine, insulin, and antidepressants.

Is child under medical treatment at present? _____ (reason) _____

FAMILY PHYSICIAN AND ADDRESS

TELEPHONE NO. OF PHYSICIAN _____

I/We authorize the appointed adult in whose care _____ has been entrusted, to consent on his/her behalf to any medical, dental, or emergency services and treatment recommended by a duly licensed physician or other competent person in the event of sickness or injury. It is further agreed that I/We assume full responsibility for all injuries and damage(s) to person and property incurred by my/our child. I/We further understand that I/we am/are responsible to report any changes to the information provided above and I/We assume full responsibility for failure to do so.

In giving this authorization, I/we hereby release First Christian Church of Hagerstown, its staff, chaperones, volunteers and sponsors from all claims, causes of action, damages and liability for all personal injuries, sickness or property damage arising by reason of any cause, matter or accident occurring during any youth or children's ministry program activity during the above-mentioned program year.

Signature of Parent / Guardian _____
Date Signed () _____
Work Phone Number () _____
Cell Phone Number

Signature of Parent / Guardian _____
Date Signed () _____
Work Phone Number () _____
Cell Phone Number