Faith Bible Fellowship CE Permission Slip

Parental Permission/Consent Form

As the parent/guardian of _____, I hereby permit him/her to attend/participate in Christian Education activities sponsored by Faith Bible Fellowship and hereby release Faith Bible Fellowship of Santee, California and all its affiliate ministries of any liability which might result due to injury, illness, or death while my child attends/participates in activities from ***January 1, 2019 to December 31, 2019***. I understand that reasonable precautions will be taken to safeguard my child. Should my child be injured or become ill during the aforementioned activities and I cannot be reached the following consent is given.

Authorization to Consent Treatment

I/We the parents/guardian of the child mentioned above do hereby authorize Faith Bible Fellowship as agents for the undersigned to consent to any x-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is rendered under the general or specific supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital where such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment of hospital care required, but is given in advance to provide authority and power on the part of the afore said agents to give specific consent to any such diagnosis, treatment or hospital care which the afore said physician in the exercise of his best judgment may deem advisable.

Further, as parent or legal guardian I am responsible for the health care decision for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child. Any policy of the church or organization sponsoring these events will be used as the secondary coverage.

Signature: _____Relationship: _____Date: ___/___/___

Medical Information

PLEASE PRINT CLEARLY

Child's Name: Last_____ First_____ Middle: _____

Address: _____ City_____ Zip_____

Home Phone ( )_____ - _____ Work Phone ( )_____ - _____

Cell Number(s) ( )_____ - _____ ( )_____ - _____

In case we cannot contact you, we should notify:

Name: _____ Phone: ( )_____ - _____ Relationship: _____

Family/child Doctor: _____ Phone: ( ) _____ - _____

Health Plan/Insurance Company: _____

Policy/Group Number: _____ Date of Last Tetanus shot: _____

Please list all allergies and any illnesses or medical conditions:

_____

_____