Bethany Presbyterian Church
Youth Permission Form and Medical Information
2025-2026

_____

Last Name First Name Middle initial Date of Birth

_____

Address

_____

Parent(s) Name(s) Parent Phone Parent Email

Youth Cell Phone: _____ Youth Email: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Permission and Liability Release

I give Permission for my child to participate in Bethany Presbyterian Church Youth Activities up to August 31st, 2026. I acknowledge that although All Bethany Presbyterian Church events are well supervised and Bethany takes all reasonable and appropriate safety measures to minimize the risk of injury to participants in church activities, Bethany Presbyterian Church cannot guarantee that the participants will be free from hazards, accidents, and/or injuries during church sponsored events and I have advised my child to abide by all safety rules provided by event supervisors or adult advisors. I agree that Bethany Presbyterian Church, a non-profit corporation, its agents, officers, employees, trustees, and volunteers will not be held liable for any personal injury, death, damage and/or loss to my child, and/or anyone claiming on my child's behalf, and I further agree to hold harmless, indemnify and defend Bethany Presbyterian Church, its agents, officers, employees, trustees, and volunteers for and from any and all damage during the time of my child's attendance and participation in church sponsored events.

Parent Signature_____ Date_____

Photo, Publicity, and Social Media Release

I give my permission that photographs or video pictures of my child participating in Bethany Presbyterian Church events may be reproduced and used by the church for its ministries, programs, social media, and church publicity.

Parent Signature_____ Date_____

Authorization for Medical Treatment/Limited Power of Attorney

1. Decide on the seriousness of the injury or illness.
2. If determined to be necessary, seek medical attention immediately.
3. As soon as reasonably possible, attempts to contact and notify parents or guardian or emergency contact person of injury or illness.
4. In the event that parents, guardian, or emergency contact person cannot be contacted, a Bethany Presbyterian Church staff member, or if no staff member is available, and adult advisor (the "Designated Adult Leader") shall act in their behalf until contact is made.
5. During the entire procedure, the Designated Adult Leader will remain with the injured or ill child, making decisions regarding treatment.
6. If necessary, the Designated Adult Leader will have the injured or ill person admitted to the hospital.

Having read and agreed with the procedures stated above, the undersigned hereby appoints the Designated Adult Leader to act alone, and delegates to such person the power to consent on our behalf to all emergency treatment and or medical care (except elective surgery) of the child determined to be necessary or desirable by the child's attending physician at the hospital. This Limited Power of Attorney shall continue until August 31st, 2026. Physician's or the hospital's medical staff may assume and rely that this authorization is currently in effect until August 31st, 2026 unless notified.

Parent Signature_____ Date_____

Medical Information

This information will be treated as highly confidential and for medical treatment purposes only.

_____

Child's physician name Phone Number Hospital

Please check any of the following that apply to your child:

_____ Allergies, including drug and food allergies-please list:_____
_____ Asthma
_____ Behavior, such as sleepwalking, bedwetting, cutting, etc. Please list:_____
_____ Diabetes
_____ Epilepsy
_____ Frequent headaches/migraines
_____ Psychiatric illness, such as depression or anxiety, please list:_____
_____ Other recent or chronic conditions of which we should be aware:_____

Please list all prescription medications including psychiatric and hormonal/birth control medications, and applicable dosage:_____

_____

_____ My child will be responsible for his/her own medication
_____ Please assign an adult to distribute his/her medication (overnight trips).
_____ Please assign an adult to ensure my child is taking his/her medication (overnight trips).

Please list any non-prescription medications your child takes (i.e Children's Benadryl, preferred allergy or pain medication):_____

Insurance Information

Insurance Name:_____ Insurance Phone:_____

ID Number:_____ Group Number:_____

Please provide a photocopy of the front and back of your insurance card to be attached here:

I understand that it is my responsibility to update this form if any new condition arises

Parent Signature:_____ Date:_____