Niles Discovery Church, 36600 Niles Blvd., Fremont, CA 94539

Youth Ministry Permission & Medical Consent Form

Activity: _____

Date(s) of Activity: _____

Minor's Name: _____

Minor's Address: _____

Minor's Phone Number: _____

I, _____, their parent or legal guardian of the above-named minor, hereby give my permission for his/her participation in the youth activities named above. I agree to direct my child to cooperate and conform to directions and instructions of personnel responsible for the activities.

I agree that in the event my child is injured as a result of his/her participation in the above-named activities, including transportation to and from these activities, whether or not caused by negligence (active or passive) of the activity or the church program or any of its agents or employees; recourse for the payment of any hospital, medical, dental, or related costs and expenses will be paid either by me or my spouse, accident, hospital or medical insurance, or any available benefit plan of mine or my spouse.

If I cannot be reached by medical staff, I consent to any emergency x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advise of or to be rendered by a physician, surgeon and dentist licenses under the Medical Practice Act and Dental Practice Act. As parent or legal guardian, I am responsible for the health care decisions of my child and am authorized to consent to services to be rendered, and no other consent is required by law.

I hereby give permission to the physician selected by the activities supervisory personnel then present to render medical treatment deemed necessary and appropriate by the physician or dentist.

_____ _____

Parent or Legal Guardian Signature Date

_____ _____

Printed Name of Parent or Legal Guardian Relationship

(continued on reverse)

Parent/Guardian Contact information:
Daytime Phone: _____ Evening Phone: _____
Cell Phone: _____

Contact Person (Other than parent): _____
Daytime Phone: _____
Cell Phone: _____

Name and Phone of Primary Doctor: _____
Health Plan/Insurance Provider: _____
& Policy Number: _____

Allergies or Medicine Allergy: _____

Please list any other special medical conditions and/or all medications the above-named minor is currently taking below.