Hempfield Church of the Brethren

Child/Youth Registration/Information Form

Including: Individual data General Permission Medical Information & Release Forms

Program Year 2021-2022

1. **Name of Child/Youth**: DOB: Age:

Grade: School: cell phone #

Youth e-mail:

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Grade: School: cell phone #

Youth e-mail:

1. **Name of Child/Youth**: DOB: Age:

Grade: School: cell phone #

Youth e-mail:

**Parent/Guardian**:

Address:

Street town state ZIP

Phone: (home) (cell phone) Other:

E-mail:

Emergency Contact:

(in the event parent/guardian cannot be reached)

Relationship to Child:

Address:

 Street town state ZIP

Phone: (home) (cell phone) Other:

E-mail:

 I hereby give permission for the youth listed below to accompany his/her church group on field trip events as planned by **Hempfield COB** throughout the 2021-2022 school year. I understand I will be notified in advance of specific individual events/activities and will complete, sign and return specific permission forms.

Youth name/names.



**Photo/Video Release:** I hereby give permission for the youth listed below to have his/her photo taken and likeness recorded in video for use by Hempfield COB Youth Ministry solely for church purposes included, but not limited to: Sunday services, event promotions, social media posts, and other online platforms such as the church website.

Youth name/names.



**Medical Release**: I, the undersigned parent/guardian of the youth listed on this form do hereby give permission for any Hempfield COB approved adults to treat said youth for minor injuries and to take him/her to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to the health of the child. I consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care that may be rendered to said minor, under the general specific instructions of (name of participant's physician) or if unavailable, by an on-call physician at a hospital or clinic. It is understood that this consent is given in advance of any specific diagnosis or treatment and is given to encourage those persons who have temporary custody of my child, in my absence, and said physician to exercise their best judgment as to the requirements of such diagnosis or said medical treatment.

Delivered to said persons entrusted with the care, custody and control of said minor child, this consent will remain effective until day of of . I understand that any and all medical expenses incurred are my responsibility and that there is no medical insurance coverage provided by Hempfield COB.

**Further, as parent/guardian of the named above, I do hereby consent that my child may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital or other medical center for rendering such services.**

Signature of parent/guardian: Date:

MEDICAL DATA

**Physician:** Phone #:

**Medical Insurance name and #:**

**Health History:**

2. Youth Name:

Check those that apply:

\_\_ Asthma \_\_ Allergies (check all that apply)

\_\_ Convulsions \_\_ 1. Animals \_\_ 5. Hay Fever

\_\_ Diabetes \_\_ 2. Insects \_\_ 6. Pollen

\_\_ Ear Infections \_\_ 3. Plants \_\_ 7. Food

\_\_ Eczema \_\_ 4. Medicines/Drugs \_\_ 8. Other

\_\_ Emotional Issues Specifications:

\_\_ Epilepsy

\_\_ Fainting

\_\_ Hearing Impaired

\_\_ Heart Disease/Defects

\_\_ Menstrual Cramps

\_\_ Motion Sickness

\_\_ Sleep Walking

\_\_ Wears Contact Lenses/Glasses

\_\_ Special Dietary Restrictions

\_\_ Other (specify)

l. Youth Name:

Check those that apply:

\_\_ Asthma \_\_ Allergies (check all that apply)

\_\_ Convulsions \_\_ 1. Animals \_\_ 5. Hay Fever

\_\_ Diabetes \_\_ 2. Insects \_\_ 6. Pollen

\_\_ Ear Infections \_\_ 3. Plants \_\_ 7. Food

\_\_ Eczema \_\_ 4. Medicines/Drugs \_\_ 8. Other

\_\_ Emotional Issues Specifications:

\_\_ Epilepsy

\_\_ Fainting

\_\_ Hearing Impaired

\_\_ Heart Disease/Defects

\_\_ Menstrual Cramps

\_\_ Motion Sickness

\_\_ Sleep Walking

\_\_ Wears Contact Lenses/Glasses

\_\_ Special Dietary Restrictions

\_\_ Other (specify)

A COPY OF THIS FORM WILL BE TAKEN ON EVERY ACTIVITY, FIELD TRIP OR OVERNIGHT EVENT THAT THIS YOUTH ATTENDS.

3. Youth Name:

Check those that apply:

\_\_ Asthma \_\_ Allergies (check all that apply)

\_\_ Convulsions \_\_ 1. Animals \_\_ 5. Hay Fever

\_\_ Diabetes \_\_ 2. Insects \_\_ 6. Pollen

\_\_ Ear Infections \_\_ 3. Plants \_\_ 7. Food

\_\_ Eczema \_\_ 4. Medicines/Drugs \_\_ 8. Other

\_\_ Emotional Issues Specifications:

\_\_ Epilepsy

\_\_ Fainting

\_\_ Hearing Impaired

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\_\_ Motion Sickness

\_\_ Sleep Walking

\_\_ Wears Contact Lenses/Glasses

\_\_ Special Dietary Restrictions

\_\_ Other (specify)