



Episcopal Parish of St. John the Baptist

Youth Group Permission Form

General Information

Youth Name _____
Parent or Guardian's Name _____
Address _____
Home Phone Number _____
Cell Phone Number _____
Parent's Email Address _____
Youth's Email Address _____

Medical Release: As the parent or legal guardian of the minor named above, I understand that, in the event that emergency medical intervention is required for my child while s/he is at a church youth event, every attempt will be made to contact me or the alternate contact provided. In the event that I or the alternate contact cannot be reached in an emergency during the course of a church youth event, I hereby give permission to the physician selected by the event leaders to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary. **Circle one: Yes No**

Liability Waiver: I understand that all reasonable safety precautions will be taken at all times by the church and its paid and volunteer staff during all youth events. I understand the possibility of unforeseen hazards and know of the inherent possibility of risk. I agree not to hold the church, its leaders, employees, or volunteer staff liable for damages, losses, diseases, or injuries incurred by my minor child, as named herein. **Circle one: Yes No**

Photo Release: I consent to the use, by the church, of any photographs or visual or audio recording in which my minor child may appear. I understand that these materials may be used for promotion of specific youth events or of the youth ministry of the congregation, including recruitment and fundraising efforts. I understand that pictures and/or recordings of my minor child will not be given or sold to any third party. **Circle one: Yes No**

Assessment of Risk: I understand that participation in any church youth event involves a certain degree of risk. I have carefully considered the risk involved and have given my child my consent to participate in church youth events. **Circle one: Yes No**

Please complete the following:

Medical Insurance Carrier _____
Medical Insurance Policy Number _____
Family Doctor and Phone Number _____
Any Drug or Food Allergies _____
Current Medication _____
Any Special Medical Conditions _____
Signature of Parent or Guardian _____
Date _____