

**2010**  
**Kid Central and Central Student Ministries**  
**(Kindergarten to 12<sup>th</sup> grade)**  
**PARENTAL CONSENT AND RELEASE FORM**

STUDENT \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY/ZIP \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ GRADE \_\_\_\_\_ SCHOOL \_\_\_\_\_

CHURCH OTHER THAN CCC \_\_\_\_\_ BROUGHT BY \_\_\_\_\_

\*\*\*\*\*

I give permission for my above-named child to go on Church-sponsored activities from  
**Jan. 1, 2010 – December 31, 2010**

\*\*\*\*\*

I hereby give permission for my child to go on activities and trips as stated above and release CENTRAL CHURCH OF CHRIST, its staff and sponsors, from responsibility and liability for any injury or illness that my child may sustain during these activities. In the event of an emergency, if I cannot be reached by phone or because of an emergency there is no time to be reached by phone, I hereby authorize an adult leader, as agent for me, to consent to any X-ray examination; medical, dental or surgical diagnosis; treatment; and hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in any hospital. I expect to be contacted as soon as possible.

(X) Signature of natural parent or legal guardian agreeing to above statement:

X \_\_\_\_\_ Date \_\_\_\_\_

Home phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Physical Handicaps, Limitations or Special Needs \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*PLEASE ATTACH A COPY OF FRONT AND BACK  
OF INSURANCE CARD AND/OR MEDICAL CARD**

**Information for medical treatment**  
**PARENTAL AUTHORIZATION FOR CONSENT**

I/We \_\_\_\_\_, hereby authorize  
(Parent/Legal Guardian)

any adult leader of Central Church of Christ to consent for necessary medical/surgical treatment for  
\_\_\_\_\_ during my/our absence  
(Minor)

**from January 1, 2010 to December 31, 2010**

The above party will/will not be able to contact me

at \_\_\_\_\_ and/or \_\_\_\_\_  
(Telephone number) (Address)

Family Physician \_\_\_\_\_ or \_\_\_\_\_

**Information for minor:**

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

Last Tetanus Shot \_\_\_\_\_

**Responsibility for Bill:**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Place of Employment \_\_\_\_\_

Insurance Company \_\_\_\_\_

Individual Number \_\_\_\_\_ Group \_\_\_\_\_

Address of medical insurance company if bill is to be sent to them \_\_\_\_\_

**Signatures:**

\_\_\_\_\_  
(Parent/Legal Guardian) (Date) (Parent/Legal Guardian) (Date)

\_\_\_\_\_  
(Witness) (Notary of Public)