Parental Consent Form

Calvary Chapel Bend

20225 Cooley Road
Bend, OR 97701

(541) 383-5097
www.ccbend.com

Child Information

Name: _____ Age: _ Birthdate: __/__/__

Address: _____

City: _____ State: _____ Zip: _____

Grade in / completed: _____ Email: _____

Phone #: _____

Emergency contact numbers:

1) Name: _____ Phone #: _____

2) Name: _____ Phone #: _____

3) Name: _____ Phone #: _____

Parental Consent

The undersigned does hereby give permission for my child, _____ to attend and participate in youth activities sponsored by Calvary Chapel Bend in Bend, Oregon (CCB).

As parent or guardian, I authorize an adult, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical, dental diagnosis or hospital care. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

The undersigned does also herby give permission for my child to ride in any vehicle designated by the Director of Youth Ministries while attending and participating in activities sponsored by CCB.

We, the guardian and the participant, also give CCB permission to use the participant's image in any publication materials (print or online) that might be used to promote the ministry in the future.

Student signature _____

Parent or Guardian Signature _____

Parent and Student Agreement

We, parent and student, understand that inappropriate behavior towards another group member, private party, church property, vehicles, the property or persons or churches we may visit during an event may result in student being financially liable for their actions. In the event of property damage, the student and parent agree to reimburse all damages caused by the student. Should it be necessary for my child to return home due to medical or disciplinary reasons, the undersigned shall assume all transportation costs.

Student signature _____

Parent or Guardian Signature _____

Medical Form

Any Allergies or Existing Conditions? (check all that apply)

☐ Food _____	☐ Heart Condition	☐ Hearing Aid	☐ Glasses
☐ Seasonal _____	☐ Convulsion / Seizures	☐ Diabetic	☐ Contacts
☐ Bee Stings	☐ High Blood Pressure	☐ Asthma	
☐ Penicillin	☐ Frequent Stomach Upset		
☐ Other _____			

Record of Sickness / Immunization (check all that apply)

☐ Chicken Pox ☐ Hepatitis

☐ Immunization Tetanus (Booster) _____

Medication / Dietary Needs (please ensure your child has these with them at all times)

1) Are there any daily routine treatments or medications required by your child?
   ☐ No ☐Yes
   If yes, please list: _____
   If yes, please indicate: ☐ Child may take on their own
   ☐ Medication must be administered by an adult
2) Are there any special dietary needs?
   ☐ No ☐Yes
   If yes, please list: _____

Insurance / Doctor Information

Hospital Insurance: ☐ No ☐Yes Insurance Company: _____
Insurance Company: _____ Policy #: _____
Doctor's Name: _____ Phone: _____
Dentist / Ortho Name: _____ Phone: _____

Parent or Guardian Signature _____