



West Side Church of Christ  
Youth Ministry  
709 West Arch  
Searcy, Arkansas 72143  
(501) 268-2951

# Parental Consent Form

I (we) give my (our) permission for \_\_\_\_\_ to attend the following event:

\_\_\_\_\_

I (We) release West Side Church of Christ from any liabilities for injuries and damages to said child or their belongings which might occur in the course of travel.

I (We), the undersigned, parent(s) or guardian(s) of \_\_\_\_\_ a minor, do hereby authorize adult workers with the West Side Church of Christ as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

Further, as parent or guardian of the minor named above, I do hereby expressly 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 harmless any physician, hospital or other medical center for rendering any such services.

## Insurance Information

Name of Medical Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Holder (Full Name with M.I.): \_\_\_\_\_

S.S. # of Policy Holder: \_\_\_\_\_ S.S. # of child: \_\_\_\_\_

Policy Holder's Place of Employment: \_\_\_\_\_

Employment Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Any allergies or other important medical information: \_\_\_\_\_

\_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_