

# BEREAN COMMUNITY CHURCH

## 2024-24 YOUTH ACTIVITY PERMISSION FORM

YOUTH'S NAME \_\_\_\_\_ AGE \_\_\_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_ GRADE (2023-24) \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONES: \_\_\_\_\_

PARENTS' E-MAILS: \_\_\_\_\_

### PARENT/GUARDIAN AGREEMENT

We, the parent(s)/guardian(s) of \_\_\_\_\_,  
Do hereby give consent for our son/daughter to participate in Berean Community Church youth activities.  
Furthermore, we also give our consent for our son/daughter to walk, or ride in the designated vehicle(s) of  
Berean Community Church, to get to all the appointed destinations during these activities.

\_\_\_\_\_  
Parent's/Legal Guardian's Signature Required Date \_\_\_\_\_

\_\_\_\_\_  
Parent's/Legal Guardian's Signature Required Date \_\_\_\_\_

### PHOTO RELEASE

- I give permission for my child's image to be posted on the Berean website/social media pages  
 I **DO NOT** give permission for my child's image to be posted on the Berean website/social media pages

### MEDICAL INFORMATION

Allergies: \_\_\_\_\_

Known medical conditions: \_\_\_\_\_

Medications being taken: \_\_\_\_\_

Family Medical Insurance provider: \_\_\_\_\_

Policy # \_\_\_\_\_ Date of last Tetanus \_\_\_\_\_

Preferred Medical Provider:  Mayo  Olmsted  Other: \_\_\_\_\_

### CONSENT FOR MEDICAL TREATMENT

As the parent or legal guardian of a participant in Berean Community Church youth activities, I hereby give my  
consent for emergency medical care prescribed by a duly licensed doctor of medicine or doctor of dentistry. This  
care may be given under whatever conditions are necessary to preserve life, limb, or well being of my dependent.

Parent/Guardian's Name (Please print): \_\_\_\_\_

\_\_\_\_\_  
Parent's/Legal Guardian's Signature Required Date \_\_\_\_\_

Parent/Guardian's Name (Please print): \_\_\_\_\_

\_\_\_\_\_  
Parent's/Legal Guardian's Signature Required Date \_\_\_\_\_