Westminster Presbyterian Church
2025 - 2026 Youth Fellowship

MEDICAL CONSENT FORM

Name _____ Age _____ Birth date _____

Mailing Address _____
Street City State Zip code

Home Phone _____ Cell phone _____

To whom it may concern:

The undersigned does hereby give permission for our (my) child, to attend and participate in the **Youth Fellowship Program** sponsored by **Westminster Presbyterian Church in Dayton, Ohio, June 2025 through August 2026.**

We (I) authorize the Rev. Nancy Hodgkins, and the adult advisors, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed in private practice or on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physicians or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for our (my) child to be transported in any vehicle designated by the adult advisors in whose care the minor has been entrusted while attending and participating in activities sponsored by Westminster Presbyterian Church.

Hospital Insurance ____ Yes ____ No

Insurance Company _____

Policy Number _____

Emergency Contact other than parent or legal guardian

Name_____ _____ Phone _____ Relationship _____

FORM CONTINUES ON REVERSE SIDE or SECOND PAGE

Please list all medications (including dietary supplements) your child takes on a regular basis, the purpose of the medication and the dosage (Please be specific.):

Please check medications that you prefer we give your child should they need/request it. If the dosage we should give is different from the recommended dosage please list.

Pain/Fever	G.I. Upset	Cold/Allergy	Motion Sickness
___ Tylenol	___ Pepto Bismol	___ Benadryl	___ Non-drowsy Dramamine
___ Advil	___ Imodium	___ Sudafed PE	
		___ Cough Drops	

Please list all medical conditions (asthma, migraines, diabetes, etc.) your child has that we should be aware of, along with instructions for handling the condition.

Please list all allergies.

Please list anything that will limit your child's participation in planned activities, along with any other information you feel we should have.

_____ _____
Participant's Signature Date

_____ Cell Phone _____
Parent's Signature
Home/Work Phone _____

_____ Cell Phone _____
Parent's Signature
Home/Work Phone _____

_____ Cell Phone _____
Legal Guardian's Signature
Home/Work Phone _____