Youth Activity Consent and Health Information Form
(Please complete both sides of this page)

Check all that apply: ____Sunday School ____Choir ____Youth Group ____Confirmation
____VBS ____Nursery ____Other

Student Name____Age_________Grade_______

Address____ City_________________Zip_________

Birthdate_____________Baptized Y N Date_____________Place______________________

Parent/Guardian Name____ St. Barnabas Member Y N

Home/Cell#__________________Work # __________________ Best time to reach you_____________

E-mail________________________________Will you please commit to checking email weekly? Y N

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Additional addresses for mailing or emailing to non-custodial parent/guardian:

____

Specific information that would assist us in working with your child:

____

____

Siblings – Name and (age): ____

____

Additional Student Information:

Has your son/daughter received Pre-Communion Instruction? ____Yes ____No

What school does student attend________________________________

Confirmand Worship Service Preference: (**check one**) (Acolyte or worship support)

______8am ______10:30am (note: 9:30 in the summer)

Do St. Barnabas Lutheran Church screened leaders have permission to contact your child via electronic communication to invite or remind them of church activities or offer congratulations on their activities/special events? [Parents will be copied] YES NO *(circle one)*

Does St. Barnabas Lutheran Church have permission for your child's name and/or photograph to appear in church written, video, and online publicity? YES NO *(circle one)*

Names and numbers of people who have your permission to pick student up from Church activities.

1.____

2.____

I grant permission for my child to participate in the St. Barnabas activities marked above.

Parent/Guardian Signature____Date____________

Name of Participant____

Does the participant have any health conditions (i.e., allergies, chronic conditions, food allergies, etc.) that we should be aware of prior to medical treatment or offering snacks? NO YES

If yes please explain, include any medications: ____

____

Emergency Contact #1_____________________________________Phone________________________

Emergency Contact #2_____________________________________Phone________________________

Name of Physician____Phone________________________

Health/Accident Insurance Carrier and Policy Number (*Optional)*_________________________________

____

Since the law requires that parental permission be obtained for most medical procedures on minors, I wish to give permission for medical staff to perform such diagnostic, therapeutic, and surgical procedures as they deem necessary for the above minor. I understand that my consent will allow procedures to be promptly carried out so that no unnecessary delays will occur with treatment. No surgical procedures will be performed, except in extreme circumstances, without parents or guardians being contacted and fully informed and their verbal consent obtained.

Signature of Parent/Guardian____Date_____________