

**YOUTH PERMISSION FORM 2008-2009**

\_\_\_\_\_  
Name of Youth

Middletown Presbyterian Church  
273 S Old Middletown Rd  
Media, PA 19063  
610-565-4080

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I/we, the parents/guardians of the above named youth, give permission for this youth to take part in the scheduled activities of the youth program of Middletown Presbyterian Church for the time period up until September 1, 2009.

I understand that in the case of an emergency, every effort will be made to contact me. If I cannot be reached at the numbers supplied, I hereby give permission to the physician selected by the adults representing Middletown Presbyterian Church to hospitalize and secure proper treatment for my child and I will be solely responsible for the payment of any charges so incurred.

NOTE: You only need to fill out one form for the whole year.

Please let us know, if any information changes during the year.

Your Name \_\_\_\_\_ Relationship to Youth \_\_\_\_\_

Address \_\_\_\_\_ Phone/Home \_\_\_\_\_

\_\_\_\_\_ Phone/Work \_\_\_\_\_

Your E-mail \_\_\_\_\_ Your Cell \_\_\_\_\_

Youth E-mail \_\_\_\_\_ Youth Cell \_\_\_\_\_

If person named above is not available in the event of an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

Personal Health/Accident Insurance Carrier \_\_\_\_\_

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

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

Date \_\_\_\_\_

(over)

General Information :	Yes	No	Explain
Food Allergies	_____	_____	_____
Insect Allergies	_____	_____	_____
Medicine Allergies	_____	_____	_____
Other Allergies	_____	_____	_____
ADHD	_____	_____	
Asthma	_____	_____	
Convulsions/Seizures	_____	_____	
Diabetes	_____	_____	
Heart Trouble	_____	_____	
Hemophilia	_____	_____	
High Blood Pressure	_____	_____	
Kidney Disease	_____	_____	
Cancer/Leukemia	_____	_____	

Explain \_\_\_\_\_

Date of last Tetanus inoculation \_\_\_\_\_

List equipment needed such as braces, glasses, contact lenses, etc. \_\_\_\_\_

Medical Information we should be aware of \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

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

Date \_\_\_\_\_