

**First Presbyterian Church of Ashland**  
**Parental Consent Form**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

City : \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School: \_\_\_\_\_ Grade currently in: \_\_\_\_\_

Parents Business Phone: (\_\_\_\_) \_\_\_\_\_

In case of emergency, notify:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

To whom it may concern:

I hereby release First Presbyterian Church of Ashland, the staff and directors, of any legal responsibility for any accident or injury that may occur during said events.  
In the event I cannot be reached in an emergency, I hereby give permission to the physician selected to hospitalize, secure proper medical treatment for, and order injection, anesthesia, or surgery for my child as named above. I understand that I am responsible for payment of hospital and/or medical bills incurred to such treatment.

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

**Medical Information:**

Dietary Restrictions: \_\_\_\_\_

Allergies to drugs, foods, etc. (please specify) \_\_\_\_\_

Activity Restrictions: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Insurance Information:**

Is the individual covered by family medical/hospital insurance? \_\_\_\_ Yes \_\_\_\_ No

Insurance Carrier : \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to youth: \_\_\_\_\_

(over)

**Permission to Treat with Over the Counter Medications:**

I hereby give permission to administer the following over-the-counter medications if it deems necessary. Dosages will be administered according to the directions on the package unless a physician directs otherwise.

Medication	Yes	No	Medication	Yes	No
Tylenol (Acetaminophen)	<input type="checkbox"/>	<input type="checkbox"/>	Suphedrine (decongestant)	<input type="checkbox"/>	<input type="checkbox"/>
Advil (Ibuprofen)	<input type="checkbox"/>	<input type="checkbox"/>	Robitussin DM (cough suppressant)	<input type="checkbox"/>	<input type="checkbox"/>
Cort-Aid (hydrocortisone)	<input type="checkbox"/>	<input type="checkbox"/>	Immodium AD (for diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>
Benedryl (antihistamine)	<input type="checkbox"/>	<input type="checkbox"/>	Neosporin (antibiotic ointment)	<input type="checkbox"/>	<input type="checkbox"/>
Tums (antacid)	<input type="checkbox"/>	<input type="checkbox"/>	Calamine Lotion (for poison ivy)	<input type="checkbox"/>	<input type="checkbox"/>

**Please attach a current copy of your medical card or proof of coverage. If your provider changes during the year, please notify the church office and send a new copy in to the office. This medical form will be kept on file in the church office. New forms will be filled out at the beginning of each school year.**