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| **Parent/ Guardian Contact Information** |
| Name(s): | Home Ph.#: |
| Address | Work Ph.#: |
| City | State | Zip | Cell ph.#:  |
| Home Church: | E-Mail: |
|  |
| Alternate cell number in case of emergency: |
| Name & Alternate cell # we can call in an emergency if unable to reach parent/guardian at the above number: Name: Cell #: Name: Cell # |
| Child’s First & Last Name | Nickname | Birthday & Year | Gender | Grade 2020/21 | Age | Allergies/Special Needs |
|  |  |  | M / F |  |  |  |
|  |  |  | M / F |  |  |  |
|  |  |  | M / F |  |  |  |
|  |  |  | M / F |  |  |  |
|  |  |  | M / F |  |  |  |
|  |  |  | M / F |  |  |  |
| **Parent/Guardian: by signing you are giving consent to all the following terms and conditions for the student ministry programs at Chestnut Ridge Baptist Church of Kings Mountain, NC.**  |
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| **Publicity release:**We do hereby authorize the use of our child/children’s photographs, taken while at any church ministry event, to be placed on the Chestnut Ridge Baptist Church Website/Social Media Sites/ and local Newspaper. This is used only to promote ministries here at the church and for Kingdom work purposes. |
| My child has permission to ride the church bus or van as pre-arranged, on field/mission/activity trips. |
| **Medical Release:** I, (we), the undersigned, parent(s) do authorize Chestnut Ridge Baptist Church as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgment may deem advisable. I, (we) hereby authorize any hospital which has provided treatment. |
| **THIS FORM WILL SERVE AS MEDICAL INFORMATION AND PERMMISSION FORM TO COVER ALL MINISTRY ACTIVITIES THROUGHOUT THE YEAR.**  **SIGNATURE(S): LEGAL PARENT-GUARDIAN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Initial indicates No Change: 2022/2023 \_\_\_\_\_ 2023/2024\_\_\_\_\_\_ 2024/2025\_\_\_\_\_\_ 2025/2026\_\_\_\_\_\_ 2026/2027\_\_\_\_