



Note: This form must be updated yearly

PARENTAL CONSENT AND MEDICAL FORM

Cascade Fellowship Christian Reformed Church
6655 Cascade Road SE
Grand Rapids, MI 49546

(Last Name of Family)

(School Year)

Child(ren) first names, birthdates, school attending and grade

- 1. _____ (Birth) ___/___/___ (school) _____/___ grade
2. _____ (Birth) ___/___/___ (school) _____/___ grade
3. _____ (Birth) ___/___/___ (school) _____/___ grade
4. _____ (Birth) ___/___/___ (school) _____/___ grade
5. _____ (Birth) ___/___/___ (school) _____/___ grade

IN CASE OF EMERGENCY CALL

Father's name/ Guardian: _____ (Home phone) _____ (Work/Cell) _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's name/ Guardian: _____ (Home phone) _____ (Work/Cell) _____

Address: _____ City: _____ State: _____ Zip: _____

OR Call _____ (A responsible person of your choice) (Phone) (Relationship to child)

Policy Holder's Name: _____ Employer _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Policy # _____ Group # _____
(Please attach a photocopy of Insurance Card)

Pediatrician/ Family Dr. _____ Phone _____ Child _____

Pediatrician/ Family Dr. _____ Phone _____ Child _____

Family Dentist: _____ Phone _____

Hospital preference (check one): Blodgett [] DeVos Children's [] Metropolitan [] St. Mary's []

Allergies: (Please indicate the specifics and for which child this relates to)

Food: _____

Medicines: _____

Insects: _____

Please list all pertinent medical information, current medications with Name, Dosage, other instructions on back of this form.

I give permission for Cascade Fellowship to use photos of my child in communications for Cascade Fellowship. YES NO

In case of emergency and I cannot be located, I hereby authorize the church leader to call our physician listed above and an ambulance if necessary. YES NO

In case I cannot be located and the church leader feels it is necessary to take my child to a hospital, I hereby grant my permission to do so and have emergency treatment by the physician. YES NO

Are there any custodial issues that would affect child pick-up? If yes, please explain.

We/ I give permission for all children listed above to attend church sponsored programs and activities.

We/I give permission to the leaders of the church to secure needed emergency medical treatment for the minor named above. In case of accident or injury during the programs or activities, We/I on behalf of our children and ourselves release the church and leaders from all liability.

Names typed in the blanks will be treated as valid signatures

Parent/Guardian signature _____ Date _____

Parent/Guardian signature _____ Date _____

Please list all pertinent medical information, current medications with Name, Dosage, other instructions here.

Child	Medication	Dosage	Notes

**If you have information pertaining to social, emotional, physical, or other needs which would help us provide a better learning environment for your child, please fill out a Special Needs form.

****Please print this form and return to the Cascade Fellowship office or email this form to office@cascadefellowship.org****