

First Baptist Church of Clarendon Child Development Center
2018 Summer Camp Permission/Insurance Form

For Illness:

The Child Development Center agrees to notify the parent or guardian whenever this child becomes ill, and the parent or guardian agrees to pick the child up thereafter as soon as possible.

Medical Attention:

If my child becomes ill or sustains injury during a CDC event, including transit, I give my permission for those in charge to administer first aid. I also consent to an x-ray examination, anesthetic, medical or surgical diagnosis, and treatment and hospital care, and the administration of drugs or medicine to be rendered to my child under the general or specialized supervision, and upon the advice of a duly licensed physician and/or surgeon. I understand that every attempt will be made to reach me and/or those authorized to be reached in the case of an emergency prior to diagnosis and/or treatment.

Field Trips:

My child has permission to attend field trips planned by and under the direct supervision of the Child Development Center Day Camp staff. If there is any exception I will notify the camp staff or the director prior to the trip.

Authorization for Departure:

The following are authorized to pick up my child (or children)

Name: _____

Date: _____

The following person(s) are NOT authorized to pick up my child (children)

Waiver of Liability:

I understand that the children are supervised at all times and that every precaution is taken to prevent accidents at all times. I relieve the staff and the First Baptist Church of Clarendon of any liability in the event of an accident or injury on the premises or while my child is attending any FBCC/CDC activity.

Name of Child: _____

Parent's Signature: _____ Date _____

The foregoing instrument was acknowledged before me this _____ day of _____

Notary Public

Emergency Information:

Child's Name: _____

Home Phone: _____

Mom Work/Cell Phone: _____

Dad Work/Cell Phone: _____

Emergency Contacts:

1. Name: _____

Address: _____

Phone: _____

2. Name: _____

Address: _____

Phone: _____

Medical Information:

Physician: _____
Name Phone

Insurance: _____

Policy # _____

Policy Holder: _____

Does your child have any allergies or dietary restrictions? If yes, what action needs to be taken?
