First Baptist Church of Clarendon

Child Development Center

Day/Summer Camp Permissions Form
2018-2019

Illness:

The First Baptist Church of Clarendon Child Development Center agrees that if your child shows any symptoms that indicate illness, you will be called to come and pick up your child within 1 hour of contacting you.

Medical Attention:

If my child becomes ill or sustains injury during a FBCC 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.

Fie ld Trips:

My child has permission to attend field trips planned by and under the direct supervision of the First Baptist Church of Clarendon Child Development Center Day/Summer 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/ren

Name: ____

Date(s) of Pick-up: ____

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

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Emergency Information

Child's Name: ____

Home Phone: ____

Parent's Work/Cell Phone: ____________________________ Relationship: ______________

Parent's Work/Cell Phone: ____________________________ Relationship: ______________

Emergency Contacts

1. Name: ____

Address: ____

Phone: ____

2. Name: ____

Address: ____

Phone: ____

Medical Information

Physician: ____

Name Phone

Policy Holder: ______________________________

Insurance: ______________________________

Policy #______________________________

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

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