

**PVMC**

**PARENTAL PERMISSION AND MEDICAL AUTHORIZATION FORM**

**Participant Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_

I give permission for my child (named above) to attend the events, field trips, and service projects associated with the PVMC. I further give permission for my child to be transported to and from events by hired and volunteer drivers authorized by the PVMC.

**Medical Release**

I hereby authorize PVMC, hospitals, licensed medical or dental providers, and their agents and employees to have access to the information contained in this form and to provide all medical or dental care, routine tests, treatment, and necessary transportation advisable for the health and safety of my child. This authorization includes the authority to consent to any x-ray examinations, anesthetic, medical procedure or treatment, and hospital care under the supervision, and upon the advice of or to be rendered by, a physician or surgeon licensed under the Medical Practice Act or dentist licensed under the Dental Practice Act for my child.

**Custody Release**

I further authorize the PVMC to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to said adult.

**Activity Release**

I further give permission for my child to participate in all supervised activities except as noted:

\_\_\_\_\_  
**Signature of Parent or Legal Guardian**                      **Printed name of Parent or Guardian**                      **Date**

**EMERGENCY CONTACT INFORMATION**

**Parent(s)/Guardian(s)**

|  | <u>Phone Numbers</u> | <u>Phone Type</u><br>(Home, Mobile, etc.) |
|--|----------------------|---|
| Name(s)                                  |                      |   |
|  |                      |   |
| Street Address                           |                      |   |
|  |                      |   |
| City                      State      Zip |                      |   |

\_\_\_\_\_  
Parent(s)/Guardian(s) Email address(es)

\_\_\_\_\_  
Other Email address(es)

**Other Emergency Contact(s)**

|  | <u>Phone Numbers</u> | <u>Phone Type</u><br>(Home, Mobile, etc.) |
|--|----------------------|---|
|  |                      |   |
| Name(s)                      Relationship to Participant |                      |   |



HEALTH CARE INFORMATION

**Participant Name:** \_\_\_\_\_

**Physician**

**Dentist**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Medical Insurance Company

\_\_\_\_\_  
Dental Insurance Company

\_\_\_\_\_  
Policy/Group Number

\_\_\_\_\_  
Policy/Group Number

\_\_\_\_\_  
Name of Policy Holder

\_\_\_\_\_  
Name of Policy Holder

Please list any allergies to drugs, foods, plants, insects, etc:

Please list any prescription medication to be taken by the participant (including what it is taken for, when it is to be taken, dosage information, and any special procedures):

Please list any non-prescription (over-the-counter) medication you do NOT want dispensed to your child:

Please list any additional information relevant to participating in PVMC activities (dietary needs; surgeries or serious injuries; chronic or recurring illness; medical conditions such as epilepsy or diabetes; psychiatric counseling or indications, etc.):

Information provided on this form will be kept strictly confidential.



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