

Basic Information:

Youth Name: _____

Street, City, Zip: _____

E-mail: _____ Cell: _____

Date of Birth: ____/____/____ School District: _____ Grade: _____

Check here if you would like to receive BYG Alerts through text messaging: ☐

Emergency Contact Information:

Name(s) of Parent(s)/Guardian(s): _____

Street, City, Zip: _____

Home Phone: _____ Alternate Phone: _____

Parent/Guardian E-mail: _____

Insurance Company: _____ Policy #: _____

Primary Care Physician: _____ Phone #: _____

Alternate Emergency Contacts if Parent/Guardian cannot be reached:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Medical conditions, limitations, allergies, medications: _____

I do hereby authorize a member of the Bethany Presbyterian Church staff or such substitute as he/she may designate, as agent for the undersigned, to consent to any x-ray, examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care for the above minor, which is deemed advisable by and rendered under the general supervision of any physician or surgeon licensed under The Provision of Medicine Practice Act or any dentist licensed under the Dental Practice Act. This authorization will remain effective while the above minor is en route to or from, or involved or participating in any program or activity of the Bethany Presbyterian Church, Bridgeville, PA. Bethany Presbyterian Church is not liable for injury and death should that be the result.

Parent/Guardian Signature: _____ Date: ____/____/____