



1001 12th Street  
Shallowater, TX 79363  
806.832.4776  
12thstreetchurchofchrist.com

# Youth Universal Permission Form

Effective Dates: January 1 – December 31, \_\_\_\_\_

Youth name \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_

Youth address \_\_\_\_\_

Youth email \_\_\_\_\_

Youth home phone \_\_\_\_\_ Youth cell phone \_\_\_\_\_

Parent/guardian name	Number(s)	Email(s)

Emergency contact name	Number(s)	Relationship

## **Parental consent**

The undersigned does hereby give permission for my child, named above, to attend and participate in any 12<sup>th</sup> Street Church of Christ children/youth ministry activities, events, retreats and childcare during the period indicated at the top of this form.

**MEDICAL TREATMENT PERMISSION:** I authorize an adult, in whose care the minor has been entrusted, to consent to any emergency x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital or emergency care facility. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child or youth pursuant to this authorization.

Youth name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## **MEDICAL INFORMATION**

### **Primary care physician**

Name \_\_\_\_\_ Name of practice \_\_\_\_\_

Phone(s) \_\_\_\_\_ Fax \_\_\_\_\_

### **Insurance information**

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

Policy/Group ID# \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder's Name (please print) \_\_\_\_\_

Allergies/Meds/Other \_\_\_\_\_

**Required:** Attach a copy of medical insurance card here.