



ST. MARK'S EPISCOPAL CHURCH

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 Children's and Youth Formation at St. Mark's Episcopal Church of Houston, Texas. I further give permission for my child to be transported to and from events by hired and volunteer drivers authorized by St. Mark's Episcopal Church.

**Medical Release**

I hereby authorize the Children's and Youth Formation leaders, St. Mark's Episcopal Church 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 Children's and Youth Formation leaders of St. Mark's Episcopal Church of Houston, Texas 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:

**Photo Release**

I further give permission for any photo and video taken of my child to be used in St. Mark's promotional materials, print and online.

\_\_\_\_ YES      \_\_\_\_ NO

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

**EMERGENCY CONTACT INFORMATION**

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

\_\_\_\_\_  
Name(s)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City                                          State      Zip

Phone Numbers	Phone Type (Home, Mobile, etc.)

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

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

**Other Emergency Contact(s)**

\_\_\_\_\_  
Name(s)                                          Relationship to Participant

Phone Numbers	Phone Type (Home, Mobile, etc.)

HEALTH CARE INFORMATION

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

**Physician**

**Dentist**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

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

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

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

\_\_\_\_\_  
Insurance Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

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

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

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

\_\_\_\_\_  
Insurance Phone Number

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

Does your child wear glasses or contacts?

Date of last tetanus shot:

For your child’s safety and our knowledge, is your child a good, fair or non-swimmer?

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 Children’s and Youth Formation activities (dietary needs; surgeries or serious injuries; chronic or recurring illness; medical conditions such as epilepsy or diabetes; psychiatric counseling or indications, etc.):

**Basic first aid will be available.  
Medication will not be administered during some events,  
such as Parent’s Day/Night Out, nursery care and others.**

Information provided on this form will be kept strictly confidential.