

First Baptist Church Jackson  
**2024 PARENTAL MEDICAL CONSENT FORM**

Name \_\_\_\_\_ Age \_\_\_\_\_

DOB: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Parent(s) Cell Phone # \_\_\_\_\_

To whom it may concern: The undersigned does hereby give permission for our (my) child, \_\_\_\_\_, to attend and participate in activities sponsored by First Baptist Church of Jackson.

We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any 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 or a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by First Baptist Church of Jackson.

Insurance Company _____
Policy Number _____

Please list any medication your child will be bringing.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

_____	Participant	Date
_____	Father	Date
_____	Mother	Date
_____	Legal guardian	Date

Please list any allergies, special needs or instructions your child may have:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_