



## Parental Consent Form/Liability Release

Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone # \_\_\_\_\_ Current Grade (or last completed) \_\_\_\_\_

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

Emergency Contact # (\_\_\_\_) \_\_\_\_\_ Name \_\_\_\_\_

Alternate Contact # (\_\_\_\_) \_\_\_\_\_ Name \_\_\_\_\_

PARENTAL CONSENT: As parent/guardian of \_\_\_\_\_ I hereby give my permission for my child or ward to volunteer and participate in the activities sponsored by Key Peninsula Civic Center Association (KPCCA) at Skate Night. I do hereby hold harmless KPCCA, its Directors, Officers, Employees, Volunteers, or Agents of said organization, for any bodily injury, illness or disease, or for loss or damage to any property or appliance of said child or ward. I assume the risk and financial responsibility for any injury or liability resulting from his/her participation. In case of a medical emergency, I understand every reasonable effort will be made to contact me. In the event I cannot be reached, I hereby give permission to secure proper treatment for, and order injection or anesthesia or surgery for my child or ward as named above. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to him/her.

I consent to the use of any video images, photographs, audio recordings, or any other visual or audio reproduction that may be taken of said child or ward while participating in activities sponsored by KPCCA.

Student Signature (if over 18) \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature (if child is under 18) \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

*Please complete and sign the reverse side of this form.  
(Office use: Program Director, file this form in your files.)*

# Medical Form

Name \_\_\_\_\_ Birth date \_\_\_\_\_

Check Boxes That Apply:

## Allergies

- Food \_\_\_\_\_
- Peanuts \_\_\_\_\_
- Other \_\_\_\_\_
- Seasonal \_\_\_\_\_
- Aspirin \_\_\_\_\_
- Penicillin \_\_\_\_\_
- Other Drugs \_\_\_\_\_

## Illnesses

- Heart Condition \_\_\_\_\_
- Convulsions/Seizures \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Fainting \_\_\_\_\_
- Frequent Upset Stomach \_\_\_\_\_
- Asthma  Migraine Headaches \_\_\_\_\_
- Other \_\_\_\_\_

**Are there any routine treatments or medications needed by your child on a daily basis?**

- No
- Yes If yes please list \_\_\_\_\_
- The child can take their medication on their own.
- The child must have this administered by an adult.

## Insurance Information

Does the child have medical insurance?

- No
- Yes

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

Insurance Policy # \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_