



First Mount Zion Baptist Church

16622 Dumfries Road, Dumfries, VA 22025 ~ 703-670-0184 - Office ~ 703.670.0296 ~ Fax ~ www.fmzbc.net
Dr. Luke E. Torian, Pastor

Vacation Bible School; July 28 - August 1, 2008
Parental / Guardian
Consent and Liability Waiver Form
(Complete One Form Per Participant - Every Participant Is Required To Have A Completed Form On File)

Participant's Name: _____ Date of Birth: ___/___/___

Home Address: _____ City, State, Zip: _____

Parent/Guardian: _____ Home Phone: (_____) _____ - _____

Grade Completed as of June 2008: _____

I (name of parent/guardian) _____, grant permission for my child, _____ to participate in First Mount Zion Baptist Church's Vacation Bible School (VBS) 2008 and all planned activities associated with this event. I take sole responsibility for my child's participation in this event and agree not to hold First Mount Zion Baptist Church and any representatives associated with this event liable or responsible for injuries, incidences, and/or medical expenses that might arise during my child's participation in VBS.

1) RELEASE: I approve the release of my son/daughter to the following persons if I am not available. ID at the time of pickup will be required. _____ (Initial) Not Applicable []

Name: _____ Contact Number: (_____) _____ - _____

Name: _____ Contact Number: (_____) _____ - _____

2) DENY RELEASE: My son/daughter SHOULD NOT be released to the following persons. _____ (Initial) Not Applicable []

Name: _____ Name: _____

Name: _____ Name: _____

3) MEDICAL MATTERS: I hereby state that to the best of my knowledge my child is in good health to participate in this event. _____ (Initial)

4) EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I understand that 911 will be called to transport my child to a hospital for emergency medical or surgical treatment and understand that I am responsible for all charges associated with this transport and treatment. _____ (Initial)

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____ - _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____ - _____

Family Doctor: _____ Phone: (_____) _____ - _____

Family Health Plan Carrier: _____ Policy Number: _____

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5) OTHER MEDICAL TREATMENT: In the event it comes to the attention of the servants / staff associated with VBS that **my child** becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, etc., the Emergency Contact(s) listed above will be contacted. _____ (Initial)

6) MEDICATIONS: I understand that the servants /staff associated with this event are not authorized to administer medications and I have made necessary arrangements to ensure that medications are administered, if needed. _____ (Initial)

7) SPECIFIC MEDICAL INFORMATION: _____ (Initial)

Allergic reactions:

Any physical limitations?

VBS should also be aware of these special medical conditions:

8) BEHAVIOR ISSUE(S):

I understand that if **my child** presents behavioral problems and prevents others from enjoying the many benefits of VBS, then a plan of action will be discussed by servants /staff associated with this event. Such plans may include dismissal from VBS. If such occurs, **parents will be contacted** and next steps will be discussed. _____ (Initial)

9) ADDITIONAL INFORMATION WE SHOULD KNOW:

By signing below, I am acknowledging that I fully understand the statements above and sign this Consent Form and Liability Waiver knowingly, freely, and willingly. My initials have been provided above stating that I have read and understand all items outlined.

Parent / Guardian Signature

____/____/____
Date