CORNERSTONE CHURCH
An Evangelical Presbyterian Church

YOUTH Permission for VBS

Personal Information:

Name: _____ DOB: ____/____/_____

Age: _____ Completed Grade _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information:

Parent/Guardian: _____ Phone: _____

Secondary Contact: _____ Phone: _____

Personal Medical Information:

Physician's Name: _____ Phone: _____

Physical Limitations (asthma, diabetes, allergies, etc.) and/or Special Instructions (allergic to certain medicines, rare blood type, wears contact lenses, etc.):

_____

_____

List ALL medication taken on a regular basis and/or any brought with you. (Prescription medications MUST have a pharmacy label and name of doctor):

_____

_____

This student herein has permission to engage in all prescribed activities except as noted.

_____

Signature of Parent/Guardian: _____ Date: ___/___/___