



ETLT Can U Hear Me Now Youth Conference(CYC)

P.O. Box 426 Moorpark, Ca 93020 (818) 549-4147 www.canuhearmentnowconference.org

Email: canuhearmentnow@endtimeslikethese.org

Consent & Medical Release Form for Under Age Youth

Conference Date: _____

Location: Camp Cedar Falls 39850 State hwy 38, Angelus Oaks, Ca 92305

Permission to be photographed & recorded by media, newspaper, website, etc.

Youth's name: _____ Today's Date _____

Birth Date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Parent Information:

____ Father ____ Male Guardian _____
Relationship

Name: _____

Address: _____

Phone: _____ Email: _____

___Mother ___Female Guardian _____
Relationship

Name: _____

Address: _____

Phone: _____ Email: _____

With whom does the youth live? _____

Youth may be taken home by: _____

Parent or Guardian signature _____

To what address should information be mailed? _____

Chaperone Information:

Name: _____

Address: _____

Phone: _____ **Email:** _____

What is your relationship to youth: _____

Name(s) of youth you will be chaperone (Max. number is 6)

Health Record:

Date of last tetanus shot:_____ Any active reaction?_____

Check if child has had the following and give details below:

___Heart trouble ___Epilepsy ___Asthma ___Diabetes ___Allergies ___Rheumatic Fever

Details:_____

Does your child require medications? If so please list them _____

Does your child have any special needs?_____

Emergency Numbers: If we are unable to reach a parent or guardian, we will call one of these numbers)

1. Name:_____ Phone_____

2. Name:_____ Phone_____

Medical Release: Parent's or Guardian's Authorization for adult in charge to consent to medical or dental treatment of minor child.

The undersigned_____ (Parent or Guardian) who resides at

_____, city of _____

state of _____, and who is a parent or legal guardian of _____,

a minor, age _____, born _____, who resides at _____

city of _____, state of _____ herein authorizes the adult sponsor of "Can U

Hear Me Now Youth Conference to consent to any x-ray, examination, anesthetic, medical or surgical supervision and on the advice of any physician or surgeon licensed to practice in the

state of _____ treatment, when the need of such treatment is immediate, and when efforts to contact me are unsuccessful.

Dated this _____ day of _____, Year _____

Signature of Parent or Guardian _____

Family physician's name, address, and phone number

Is there any further information that might help us better care for your child?

The request for the guardian's social security number is only for emergency purposes. The SSN will be used to verify the guardian's signature by hospitals or other emergency organizations when an emergency has occurred that involves your child.

Social Security Number of Guardian

Please email, mail or deliver this form before child arrives onsite.

Parent or Guardian: _____ **Phone** _____

Email: _____

Chaperone: _____ **Phone** _____

Email: _____