

FAMILY MINISTRY FORM

FAMILY NAME: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

Primary Phone #: (____) _____ Email Addresses: _____

FATHER: _____ Cell Phone #: (____) _____

MOTHER: _____ Cell Phone #: (____) _____

BEST CONTACT METHOD: _____

EMERGENCY CONTACT: _____ PHONE: _____
(Other than above)

For ELEMENTARY/MIDDLE SCHOOL/HIGH SCHOOL

NAME	Birthdate	Grade	School	Cell Phone
1.				
Allergies/Medical Concerns:				
2.				
Allergies/Medical Concerns:				
3.				
Allergies/Medical Concerns:				
4.				
Allergies/Medical Concerns:				
5.				
Allergies/Medical Concerns:				
6.				
Allergies/Medical Concerns:				
7.				
Allergies/Medical Concerns:				
8.				
Allergies/Medical Concerns:				

Participation Authorization and Consent to Emergency Medical Treatment

I, the undersigned, certify that I am the parent or legal guardian of _____ (hereafter the “minor child”).

I hereby give my consent to have my minor child participate in the ministry activities of Lakeside Community Church of the Nazarene from September 1, 2025 to August 31, 2026.

I recognize that there are risks involved in participating in the Church’s ministry activities and hereby assume all risk of injury, harm, damage, or death to my minor child in connection with his/her participation.

To the fullest extent permitted by law, I release Lakeside Community Church of the Nazarene, its trustees, officers, directors, employees, agents and representatives from any injury, harm, damage or death which may occur to my minor child while participating and agree to save and hold harmless Lakeside Community Church of the Nazarene, its trustees, officers, directors, employees, agents and representatives from any claims arising out of my minor child’s participation.

Further, being the parent or legal guardian of the minor child, I do consent to any medical, surgical, x-ray, anesthetic, or dental treatment that may be deemed necessary for my minor child. I understand that efforts will be made to contact me prior to treatment but, in the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. As parent or legal guardian, I understand that I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital care or treatment that is given to my minor child. Any insurance policy of the church or organization sponsoring this event will be used as the secondary coverage.

YES / NO I give Lakeside Community Church permission to photograph my son/daughter and include his/her picture in internal publications (bulletin boards/slide shows, etc.) and in the Lakeside website, local publicity information, and social networking sites, such as the Church’s Facebook photo albums, etc.

YES / NO I give Lakeside Community Church Pastors and its authorized group leaders permission to text my Middle School/High School student.

Executed this _____ day of _____, 20__.

Signature _____

Printed Name _____

Witness (Church Representative) _____

Witness (Church Representative) _____

****Please submit a copy of your insurance card along with this form unless one is already on file.*