

**Christian Fellowship Chapel**  
1296 Cambrian Road  
L3V 6H4  
705-326-8030

Youth Consent form for \_\_\_\_\_ to  
Day Month Year  
\_\_\_\_\_  
Day Month Year

Name of participant: \_\_\_\_\_  
First name Last name

OHIP number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
First name Last name  
\_\_\_\_\_  
Telephone # Cell #

Secondary Emergency Contact: \_\_\_\_\_  
First name Last name  
\_\_\_\_\_  
Telephone # Cell #

I/We the parents or guardians authorize the Christian Fellowship Chapel youth leaders/volunteers to sign a consent for medical treatment and to authorize any physician or hospital to provide medical assessment, treatment or procedures for the participant named above.

I/We the parents or guardians undertake and agree to indemnify and hold blameless the Pastor, ministry volunteers and Christian Fellowship Chapel leadership from and against any loss, damage or injury suffered by the participant as a result of being part of the youth event as well as of any medical treatment authorized by the supervising individuals representing the Chapel.

I/We the parents or guardians have received a list of planned events (and relevant contact phone numbers) but are aware that events may be added or changed.

Parent/Guardian signature: \_\_\_\_\_

Print name of parent/Guardian: \_\_\_\_\_  
First name Last name

Dated: \_\_\_\_\_  
Day Month Year