

MEDICAL RELEASE FORM
Church of Christ, Congregational, UCC in Millis
508-376-5034

Name of Youth _____ Birth date _____

Address _____ Phone _____

Name of Parent/Guardian _____ Phone _____

Youth's physician _____ Phone _____

Emergency contact _____ Relationship _____ Phone _____

Emergency contact _____ Relationship _____ Phone _____

Heath History (please check all that apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Seizure disorders | <input type="checkbox"/> Physical disability | <input type="checkbox"/> Appliances (retainers, contact lenses etc) |
| <input type="checkbox"/> Stomach upsets | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental disability | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Vision/hearing impairment | <input type="checkbox"/> Emotional/behavioral disability | <input type="checkbox"/> Motion sickness |

If any of above is checked, please give important details _____

Allergies _____

Other _____

Date of last tetanus shot _____

Is your son/daughter taking a prescription or non-prescription medication? Yes No

1. Medication _____

Dosage and frequency of dosage _____

2. Medication _____

Dosage and frequency of dosage _____

3. Medication _____

Dosage and frequency of dosage _____

Can your son/daughter self administer his/her medication? Yes No

If the answer is No, arrangements must be made with the adult in charge.

I give my child permission to administer his/her own medications _____

Signature of parent

In the case of minor illness or discomfort, I give the Youth Group Advisors permission to dispense Acetaminophen (Tylenol,) Ibuprofen (Advil,) and over the counter motion sickness medication as needed.

Signature of parent

Youth's insurance carrier and policy number _____

Name of primary insured _____ Primary insured's Social Security # _____

Other pertinent information _____

Statement of Consent

I, the undersigned, parent/legal guardian of _____

Name of youth

do hereby consent to any x-ray exam, anesthetic, medical diagnosis or treatment and hospital services that may be rendered to said

minor, under the general or specific instructions of _____

Name of youth's physician

or, if unavailable, two on-call physicians at a hospital or clinic. It is understood that this consent is given in advance of any specific

diagnosis or treatment and is given to encourage those persons who have temporary custody of my child, in my absence, and said

physician to exercise their best judgment as to the requirements of such diagnosis or said medical treatment.

This consent will remain effective until the ___31st___ day of ___August___, 2010___ delivered to said persons entrusted with

the care, custody and control of said minor child. I understand that any and all medical expenses incurred are my responsibility and

that there is not medical insurance coverage provided by Church of Christ, Congregational, United Church of Christ.

Signature of Parent/Guardian

Date