**[Parents, please fill out and return to person in charge of activity or to the church office.]**

# First Church of Christ
# Children's and Youth Ministry Medical Release

**Student's Name**_____ Today's Date_____

**Medical Information**
Youth's Physician _____ Phone _____
Address _____
Insurance Company_____ Policy #_____
Name of Primary Insured _____

**Health History** (please check all that apply)
___Frequent colds ____ Seizure disorders _____ Physical disability Sleep disturbances

___Stomach upsets _____Diabetes _____Learning disability _____Motion sickness

____Asthma _____Vision/Hearing impairment _____Emotional/Behavioral disability ____Appliances (contact lenses, retainers, etc.)

Other_____

Allergies_____

If any of the above are checked, please provide important details (attach separate page if needed):

Date of last tetanus shot _____

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

If yes, please provide the following:

Medication_____ Dosage & time(s) administered_____

Medication_____ Dosage & time(s) administered_____

If there are more medications, please list them on a separate sheet of paper and attach it to this form.

**Can your son/daughter independently take the proper dosage of medication at the right times?**
___Yes ____No

If the answer is no, please contact the adult in charge to make appropriate arrangements.

I give my child permission to administer his/her own medication X_____

**STATEMENT OF CONSENT**

I do hereby consent to an x-ray exam, anesthetic, medical diagnosis or treatment and hospital services that may be rendered to said minor, under the general or specific instruction of _____ (youth's physician) or, if unavailable, the attending physician at a hospital or clinic. I understand that in an emergency, whenever possible, an attempt will be made to communicate with me prior to use of this permission and understand that this consent is 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. I understand that any and all medical expenses incurred are my responsibility, and that there is no medical coverage provided by First Church of Christ.

**Signature of parent/guardian _____ Date_____**