



MEDICAL RELEASE FORM

To be filled out by parent/guardian and returned as soon as possible. Info is confidential.

Personal Information

Son/daughter's name _____

Age _____ Birth Date _____ Address _____

City _____ Zip _____ Phone _____

Name of Parent/Guardian _____

Address (if different) _____

City _____ Zip _____ Phone _____

Emergency contact (Different than above)

Name _____ Phone _____

Health Information Necessary for Proper Care and Protection

In order to assist any needed medical personnel in caring for your teen please fill out the following:

Describe any Health factor that makes it advisable for your son/daughter to limit physical activity:

Please state any limitations _____

Any known allergy to medication _____

Directions for current medications _____

Has a tetanus shot been given within last five years? _____

Name of family Physician _____

Address _____ Phone _____

Any recent exposure to a communicable disease? _____ Yes _____ No

If yes, please explain _____

May have aspirin if needed? _____ Yes _____ No Aspirin substitute? _____ Yes _____ No

Does any food cause allergic reaction? _____ If so, please explain _____

Is there something else we should know about your son/daughter?

If a serious emergency would arise, it might be necessary for a physician to attend to your son/daughter before staff could get in touch with you or your designated physician. By signing below:

Permission is granted for my child to receive medical care if: (1) such care is deemed necessary by person in charge of event; (2) the proposed medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain my parental consent would reasonably jeopardize the life, health, or well-being of the teen affected; (3) I cannot be personally contacted.

Authorization for Medical Treatment & Parent Permission

I (name of parent/guardian) _____ hereby authorize that emergency medical and/or surgical care may be provided for my son/daughter. I also hereby release and discharge Adoration Church Inc., along with other chaperoning adults from all claims of damage, demands, actions, whatsoever in any manner arising or growing out of my son/daughter's participation in the church's youth activities. Except for those limitations named on this health form, I certify that (teens name) _____ is healthy and fit to participate in this church's youth events.

Signature _____ Date _____

Relationship _____ Insurance company & Agent _____

Policy number _____ Limit of liability _____

The Following Section Must Be Completed By Notary Public if the Participant is a Minor

Before me, a notary Public, in and for said County and State/Province, this _____ day of the year _____, personally appeared _____ and acknowledged execution for the following

IN WITNESS WHEREOF, I have hereunto set my hand and Notary Seal.

STATE/ PROVINCE IF: _____

Notary Public signature: _____

Notary Seal

Commission expiration date: _____