

PARENTAL RELEASE AND MEDICAL INFORMATION FORM

(Please print/type all information)

Name of child/youth _____ DOB _____ Age _____

Parent/guardian name _____

Address _____

City _____ ST _____ Zip _____

Release Statement

I hereby release First Presbyterian Church, its staff and chaperones from responsibility and liability for an injury or illness that my child may sustain during the events and activities in which my child participates. In the event of an emergency, I expect to be contacted as soon as possible. In the event that I am not able (as well as the alternate contact) to be reached, I hereby authorize an adult leader of this activity, as agent for me, to consent to any x-ray examination; medical, dental or surgical diagnosis; treatment; and hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) licenses to practice under the laws of the state where the services are rendered, either at a doctor’s office or in any hospital.

This contract is legal and valid for one year from the date of signature.

Signature of parent _____ Date _____

EMERGENCY CONTACT INFORMATION

NAME _____ **Relationship to child** _____

BEST phone number to reach you _____

Alternate numbers _____

NAME _____ **Relationship to child** _____

BEST phone number to reach you _____

Alternate numbers _____

NAME _____ **Relationship to child** _____

BEST phone number to reach you _____

Alternate numbers _____

See backside for medical information

MEDICAL INFORMATION:

Food Allergies: Yes _____ No _____

type(s) _____

Prescription Medication Allergies? Yes _____ No _____

type(s) _____

Any pre-existing or present conditions we should be aware of? _____

Insect Sting Allergy: Yes _____ No _____ **Heart Condition:** Yes _____ No _____

Allergies (seasonal): Yes _____ No _____ **Diabetes:** Yes _____ No _____

Hay Fever: Yes _____ No _____ **Headaches:** Yes _____ No _____

Asthma: Yes _____ No _____ **Frequent upset stomach:** Yes _____ No _____

Tetanus shot date: _____

Physical Handicap: Yes _____ No _____ (if yes, please explain) _____

Activity restrictions: Yes _____ No _____ (if yes, please explain) _____

Does your child wear glasses? Yes ___ No ___ Does your child wear contacts? Yes ___ No ___

CURRENT MEDICATIONS

Name of medication _____

Dosage _____ When _____

Family doctor _____ Phone _____

Name of medication _____

Dosage _____ When _____

Family doctor _____ Phone _____

INSURANCE INFORMATION

Name of insurance company _____

Name on policy _____ Policy/group number _____

Employer _____