Youth Ministries
Permission/Medical Release Form
Valid September 2008 – August 2009

Name ________________________________ Phone ____________________

Address _______________________________ City/Zip ___________________

School ________________________________ Grade (2008-'09) ____________

Date of Birth ______/_______/_________
Month Day Year

Parent Contact Information:

Mother's Name ___________________ Father's Name _______________________

Mother Cell ______________________ Father Cell _________________________

Mother Work _____________________ Father Work ________________________

Emergency Name ______________________ Relation to Youth ________________________

Emergency Phone _______________________

Medical Information:

Does youth have any known allergies? ____Yes ____ No

Allergies to medications:____

Food allergies:____

Other Allergies :____

List any dietary restrictions: ____

Parent/Guardian Authorization:

My child has permission to take part in all Central Kitsap Presbyterian Church activities under supervision unless limitations are noted above, and I agree that the church or church personnel will not be held responsible for accidents arising there from. I hereby give permission to the church to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the church to arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the church to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian_____________________________________ **Date**___________

Health History: *(Check any that apply)*

____Epilepsy or seizures	____Frequent ear infections	____Menstrual problems	____Heart disease
____Frequent sore throats	____Headaches	____Bed-wetting	____Diabetes
____Back pain or strain	____Alcohol/drug addiction	____Attention Deficit Disorder	____Asthma

_____Other: ____

Pertinent past medical treatment: ____

____

Is the youth current on all immunizations needed for school? ____Yes _____ No

Date of Last Tetanus shot:____________________ Blood Type _____________ *(if known)*

Does the youth have a health condition *(e.g. allergies, chronic conditions)* **or special circumstances which may affect program participation, special housing need, or anything we ought to know prior to emergency treatment?** _____Yes ____ No

If yes, please explain: ____

____

Family Medical Insurance: ___Yes _____ No Name of Insured: __________________________

Carrier: ______________________ Group # ________________ Policy #______________________________

Name of family physician________________________________ Phone (_____)__________________

Is youth presently taking or using any type of medication(s) or drug(s)? _________Yes _____ No

If yes, Specify and complete med report.

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at the church function. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Med #1 ________________________Dosage____________Specific times taken each day__________________

Reason for taking ____

Med #2______________________________Dosage____________Specific times taken each day____________

Reason for taking ____

Med #3______________________________Dosage____________Specific times taken each day____________

Reason for taking ____