

Medical Release/History Form

Child/Dependent's Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Parent/Guardian Name _____ Email of parent/guardian _____

Work Phone _____ Cell phone _____

Physician's Name _____ Physician's Phone number _____

EMERGENCY CONTACT (if listed parent/guardian is unavailable)

Name _____ Relationship to Child _____ Phone _____

Address _____ City _____ State _____

HEALTH HISTORY

Known Medical Problems: _____

Medications to be taken with directions: _____

Medication Allergies: _____

History of Asthma? Y N History of seizures or other loss of consciousness? Y N

History of heart problems? Y N If yes, nature of problem: Last Tetanus Shot (Td): _____

May be given as necessary: Ibuprofen? Y N Tylenol? Y N

Health Insurance Company: _____

Group Number: _____ ID Number: _____

Insured's Social Security number: _____

I hereby give my consent in advance to the designated leaders of _____ and to the physicians or hospital selected by them to render emergency treatment as in their judgment is reasonably necessary, including, but not limited to, hospitalization, diagnosis including taking specimens and x-rays, giving blood transfusions and medications, anesthesia and surgery for my dependent listed above. I understand that the leaders of this activity will attempt to contact me before securing medical treatment, but that this consent is given in case I am not available in an emergency.

I specifically release the leadership of this activity from any and all claims, loss, cost, damage or expense arising out of or from any accident or other occurrences causing injury to any person or property.

Signature of Parent/Guardian _____ Date _____ Signature of non-related adult witness _____ Date _____