

MEDICAL CONSENT FORM

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(MUST BE PHOTOCOPIED FRONT TO BACK)

Last name _____ First name _____

Home phone number _____ Male _____ Female _____ Birthdate _____

Age _____ Grade (just completed) _____ Social Security Number _____

Parent(s)/Guardian(s) name(s) _____

Parent(s)/Guardian(s) address(es) _____

Parent(s) work phone number(s) _____

Parent(s) pager or mobile phone numbers _____

Emergency Contact (Other than parent/guardian – name/relationship/phone numbers) _____

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Emergency & Health Information

Does youth have...(if "yes" please explain)

_____ yes _____ no Food or environmental allergies? _____

_____ yes _____ no Heart condition? _____

_____ yes _____ no Other? _____

Is youth subject to...(if "yes" please explain)

_____ yes _____ no Fainting? _____

_____ yes _____ no Sleep walking? _____

_____ yes _____ no Upset stomach? _____

_____ yes _____ no Motion sickness? _____

_____ yes _____ no Other? _____

Does youth have a reaction to...(if "yes" please explain)

_____ yes _____ no Bee sting? _____

_____ yes _____ no Penicillin? _____

_____ yes _____ no Other drugs? _____

_____ yes _____ no Poison Ivy, oak, sumac? _____

_____ yes _____ no Other? _____

Please indicate ANYTHING else which leaders should know to avoid or help deal with your youth's health _____

Date of last tetanus shot: _____

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You have my permission to give my youth:

| | | | | | |
|------------------------------|-----------------------------|--|------------------------------|-----------------------------|--------------------------------------|
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Robitussin (cough medicine) | <input type="checkbox"/> yes | <input type="checkbox"/> no | Dramamine (for motion sickness) |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | acetaminophen (Tylenol) | <input type="checkbox"/> yes | <input type="checkbox"/> no | Roloids, Mylanta (antacid) |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | diphenhydramine (Benadryl) | <input type="checkbox"/> yes | <input type="checkbox"/> no | ibuprofen (Advil, Motrin) |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | topical antibiotic ointment (polysporin) | <input type="checkbox"/> yes | <input type="checkbox"/> no | topical cortisone ointment (Cortaid) |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Pepto Bismal | <input type="checkbox"/> yes | <input type="checkbox"/> no | Solarcaine spray/lotion/ointment |

EMERGENCY PROCEDURE: IN THE EVENT OF ANY EMERGENCY, LEADERS WILL ATTEMPT TO FIRST CONTACT PARENT/GUARDIAN/DOCTOR! In case this is impossible, note below:

- yes no 1. With my signature, I hereby authorize First Aid by staff or youth workers.
- yes no 2. With my signature, I hereby authorize emergency medical care by hospital staff and/or doctor selected by church staff or youth workers.
- yes no 3. With my signature, I hereby authorize doctor(s) selected by church staff or youth worker to hospitalize, secure treatment for, and to order injection, anesthesia, blood transfusions, or surgery.

If parent/guardian has answered "NO" to any of the above, parent/guardian must indicate procedure to be followed in the event youth workers are unable to contact parent/guardian/designee _____

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Insurance Information

My youth has health insurance yes no. If yes, complete the information below.

Insurance Company _____

Policy/Certificate number _____

Name of Policy Holder _____

Pre-certification required? yes no If yes, phone number _____

Doctor's name and phone number _____

Parent/Guardian Signature _____ Date _____

Notary's signature _____