Central Reformed Church Youth Ministry

HEALTH HISTORY AND RELEASE FORM

Participant's Name: _____ Birth Date: _____

Parent/ Guardian's Name: _____

Home Address: _____

Home Phone: (_____)_____ Cell: (_____)_____

Work Phone: (_____)_____

(in case parent/guardian cannot be reached…)

Emergency Contact Name: _____ Relationship: _____

E.C. Phone (most likely to work): (_____)_____

Name of Physician: _____ Phone: (_____)_____

Name of Dentist: _____ Phone: (_____)_____

HEALTH HISTORY (Check all that apply)

_____Frequent Ear Infections
_____Heart Defect/Disease
_____Convulsions
_____Asthma
_____Diabetes
_____Bleeding/Clotting Disorders
_____Mononucleosis (Give date!)

Allergies

___Insect Stings
___Penicillin
___Other Drugs

** Date of most recent tetanus shot: _____

List and describe any recent or chronic health illnesses, injuries, surgeries, etc:

List any medications participant will bring and be taking:

I certify that the information provided herein is correct and I give the above named minor my permission to participate in all activities except as noted.

AUTHORIZATION FOR TREATMENT: *I hereby give my permission to the medical personnel selected by the Youth Director to order x-rays, routine tests, treatment and necessary related transportation for the above named participant. If I cannot be reached in an emergency, I hereby give permission to the physician selected by the Youth Director to secure and administer treatment including hospitalization for the above named student.*

Signature of Parent/Guardian: _____ Date: _____

INSURANCE INFORMATION

Company: _____

Policy Holder: _____

Group #: _____ Contract #: _____

Last edited 12/7/2007