

MEDICAL/PERMISSION AND RELEASE FORM

CHILD'S NAME _____ AGE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME TELEPHONE _____ CELL NUMBER _____
IN EMERGENCY NOTIFY: _____ PHONE _____
FAMILY PHYSICIAN _____ PHONE _____
MEDICAL INSURER _____ POLICY # _____
IMMUNIZATIONS: ___TETANUS ___POLIO BOOSTER ___MEASLES ___MUMPS
OTHER: _____

PAST MEDICAL HISTORY

(Check box to give appropriate information.)

___Asthma ___Sinusitis ___Bronchitis ___Kidney Trouble ___Diabetes
___Heart trouble ___Dizziness ___Stomach upset ___Hay fever ___Other
(List Other) _____

ALLERGIES: Food _____
Penicillin or other drug (name) _____
Insect stings/bites _____
Poison sumac, oak, or ivy _____
Previous surgery or serious illnesses _____

Any current medications (list): _____
Special diet (name): _____
Childhood diseases: ___Chickenpox ___Measles ___Mumps ___Whooping Cough
Other (list): _____

PERMISSION FOR MEDICAL TREATMENT

My permission is granted for First John Church, including its chaperones and staff in charge to obtain necessary medical attention in case of sickness or injury to my child. I understand this is also an authorization for blood transfusions if deemed necessary by proper medical authorities.

I, the undersigned, do hereby verify that I am a parent or legal guardian of the above named child and that the above information is correct and I do hereby release and forever discharge all sponsors and First John Church from any and all claims, demands, actions or cause of action, past, present or future arising out of any damage or injury while employed by or participating in any youth activities involving First John Church.

Dated this _____ day of _____, 20____.

State of _____ County of _____

Signature of Parent/Legal Guardian _____