Medical Consent Form

(PAGE 1 OF 2) (MUST BE PHOTOCOPIED FRONT TO BACK)

Last Name:_____ First Name:_____

Home Phone Number:_____ Male:☐ Female:☐ Birthdate:_____

Age:_____ Grade (just completed):_____ _____

Parent(s)/Guardian(s) Name(s):_____

Parent(s)/Guardian(s) Address(es):_____

_____

Parent(s) Work Phone Number(s):_____

Parent(s) Pager/Mobile Phone Number(s):_____

Emergency Contact (Other than Parent/Guardian – Name/Relationship/Phone Number(s):_____

_____

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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 stings?

_____

☐ yes ☐ no Penicillin?

_____

Emergency & Health Information, Cont.

☐ 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:_____

You have my permission to give my youth:

☐ yes ☐ no cough medicine (Robitussin)
☐ yes ☐ no acetaminophen (Tylenol)
☐ yes ☐ no iphenhydramine (Benadryl)
☐ yes ☐ no topical antibiotic ointment (Polysporin)
☐ yes ☐ no Pepto-Bismol
☐ yes ☐ no Dramamine (for motion sickness)
☐ yes ☐ no Rolaids, Mylanta (antacid)
☐ yes ☐ no ibuprofen (Advil, Motrin)
☐ yes ☐ no topical cortisone ointment (Cortaid)
☐ yes ☐ no topical anesthetic (Solarcaine)

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:_____