

DUE WEST UMC YOUTH MEDICAL FORM

(valid for one year from date of signature of parent/guardian)

NAME OF YOUTH _____ GENDER _____ GRADE _____ DOB _____
PARENT OR GUARDIAN _____
ADDRESS _____ ZIP _____
PHONE: HOME _____ WORK _____
PAGER _____ MOBILE _____

PERSONS TO NOTIFY IN EMERGENCY IF PARENTS OR GUARDIANS CANNOT BE REACHED:

1) _____ RELATIONSHIP TO CHILD _____ PHONE _____
2) _____ RELATIONSHIP TO CHILD _____ PHONE _____

INSURANCE COMPANY _____ IDENTIFICATION # _____
PHYSICIAN NAME _____ PHONE _____
DENTIST NAME _____ PHONE _____
DATE OF LAST TETANUS SHOT _____
KNOWN DRUG ALLERGIES _____

WRITE "YES" ON THE LINE TO ANY AND ALL OF THE FOLLOWING THAT APPLY TO YOUR CHILD

ALLERGIES _____ BEE STINGS _____ INSECT BITES _____ FOODS _____
ASTHMA _____ FAINTING _____ HIVES _____ POISON IVY OR OAK _____
OTHER ALLERGIES OR CONDITIONS _____

If any of the above are "YES", please submit a statement of how the child has been treated and with what medication. Please list any other special information of which we should be aware. (ie: diabetes, epilepsy, etc.)

Any youth who might require medication while attending an event sponsored by Due West UMC must supply the following information.

NAME OF MEDICATION: _____

REASONS FOR TAKING MEDICATION: _____

DATE(S), TIME(S), AND AMOUNT OF DOSAGE: _____

I give permission for this medication to be dispensed to my child by an adult volunteer or staff member. YES NO
I give permission to dispense Tylenol (acetaminophen) and/or ibuprofen to my child for pain or fever. YES NO

MEDICAL TREATMENT AND RELEASE FORM:

I understand that if my child is attending an event with a youth, choir, or other group of the Due West United Methodist Church, in the event that he/she is involved in an accident or becomes ill, the adult staff or volunteers of the church will attempt to reach me. If the adult staff or volunteers are unable to reach me, I hereby give permission to them to obtain needed medical treatment for my child from any medical practitioner or at any medical facility. I agree that I will be financially responsible for any such medical treatment. I also understand that the church staff and volunteers will take all reasonable steps to ensure the safety of my child. However, accidents do sometimes occur. Therefore, I release the church, its staff members and all volunteers from any liability related to my child participating in any church activities. My release is given on behalf of all parents, relatives, guardians, and other interested in my child. I further agree to indemnify the church for any judgements or other expenses it may incur due to my child participating in church activities. I understand this medical treatment and release form is **valid for one year from the date of the parent/guardian signature**. Therefore I will update it if there are any changes in the information given above during this time period.

(Signature of Parent/Guardian)

(Date)

Notary Public: _____