Medical Release and Permission Form

Name of participant_____Birthdate_____

Address_____

Telephone_____Email_____

Name of parent or guardian_____

Work telephone_____Cell phone_____

Emergency contact_____Tel:_____

Emergency contact_____Tel:_____

Physician of participant_____Tel:_____

Health History (please check all that apply)

_____Frequent colds	_____Seizure disorders	_____Physical disability
_____Stomach upsets	_____Asthma	_____Mental disability
_____Diabetes	_____Vision/hearing impairment	_____Emotional/behavior disability
_____Motion sickness		
_____Sleep disturbances	_____Appliances (retainers, contact lenses, etc.)	

Other_____
_____
_____

Allergies_____
_____
_____

If any of the above is checked, please give important details_____
_____
_____
_____

Date of last Tetanus shot_____

Is participant taking a prescription or non-prescription medication? ___yes___no
If yes, please list medication, dosage and frequency of dosage.
_____
_____
_____
_____

Can the participant be expected to take the right amount of medication
At the proper time? ____yes____no
If the answer is no, arrangements must be made with the adult in charge.

I give my child permission to administer his/her own
medications_____

Signature of parent/guardian

Participant's insurance carrier and policy number_____

Name of primary insured_____

Primary insured's Social Security number_____

Other pertinent information (ie. Bedwetting, menstrual problems, eating disorders, homesickness, unusual behavior, etc.)

_____
_____
_____
_____

Statement of Consent

I, the undersigned, parent/legal guardian of _____
Do hereby consent to any x-ray exam, anesthetic, medical diagnosis or treatment and hospital services that may be rendered to siad minor, under the general or specific instructions of

_____
Name of participant's physician

Or, if unavailable, two on-call physicians at a hospital or clinic. It is understood that this consent is given in advance of any specific diagnosis or treatment and is given to encourage those persons who have temporary custody of my child, in my absence, and said physician to exercise their best judgment as to the requirements of such diagnosis or said medical treatment.
This consent will remain effective until the _____day of _ _____200_____Delivered to said persons entrusted with the care, custody and control of said minor child. I understand that any and all medical expenses incurred are my responsibility and that there is not medical insurance coverage provided by ____United Church of Christ, Massachusetts Conference

_____ _____
Signature of parent/guardian ***Date***