

YOUTH GROUP MEDICAL RELEASE FORM

Name of Youth: _____ Birth date: _____

Address: _____

Emergency Contact Information:

Parent 1

Parent 2

Name: _____ Name: _____

Cell Ph: _____ Cell Ph: _____

Home Ph: _____ Home Ph: _____

Work Ph: _____ Work Ph: _____

Youth's Medical Information:

All information provided is considered private and confidential and will only be shared with adult leaders.
This medical history would accompany your child in the event of emergency so accuracy is vital.

Physician: _____ Phone: _____

Health Insurance Provider: _____

Health Insurance Member Number: _____

Yes / No Does your child have any allergies?

Please list: (Ex. food, seasonal, etc., please describe reaction if in contact with allergen):

Yes / No Does your child have asthma?

Yes / No Is an inhaler needed?

Yes / No Does your child take any medications, prescribed or over the counter?

Please list:

Yes / No Will this/these be with them on the trip?

Any other general information or specific medical issues we should be aware of?
Ex. anxiety, migraines, claustrophobic, fear of heights, the dark, etc.

I give permission for the following medications to be administered without prior approval should the need arise:

Tylenol Yes ____ No ____

Ibuprofen Yes ____ No ____

Date of last Tetanus Shot: _____

Yes / No I give permission for The First Congregational Church, Shrewsbury MA to use photos/videos taken during Youth Group events for church purposes and publicity.

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 said minor, under the general or specific instructions of _____ (youth'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 are responsible for my child, in my absence and said physician, to exercise their best judgment as to the requirements of such diagnosis or said medical treatment.

YEAR 1:
Parent/Guardian Signature: _____ Date: _____

YEAR 2:
Parent/Guardian Signature: _____ Date: _____

YEAR 3:
Parent/Guardian Signature: _____ Date: _____

YEAR 4:
Parent/Guardian Signature: _____ Date: _____