

MEDICAL RELEASE FORM

Name of Youth _____ Birthdate _____

Address _____

Phone: (home) _____ (cell) _____ (work) _____

Name of parent/guardian _____

Youth's physician _____ Phone _____

Emergency contact _____ Phone _____

Health history (please check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Physical impairment |
| <input type="checkbox"/> Appliances (retainer, contact lenses, etc.) | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Mental impairment | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Emotional disability | <input type="checkbox"/> Vision/hearing impairment | <input type="checkbox"/> Motion sickness |
| | | <input type="checkbox"/> Behavioral problems |

Other (describe) _____

Allergies (describe) _____

Give important details of items that are checked: _____

Date of last tetanus shot _____ Is your son/daughter taking a prescription or non-prescription medication?
____ Yes ____ No If yes, complete the following:

Medication _____ Dosage and frequency _____

Medication _____ Dosage and frequency _____

Medication _____ Dosage and frequency _____

Can your son/daughter be expected to take the right amount of medication at the proper time?

____ Yes ____ No (If the answer is no, then arrangements must be made with the adult in charge.)

____ I give my child permission to administer his/her own medications.

All medications, both prescription and non-prescription, MUST be in the original container and properly labeled. This applies even if your son/daughter has permission to self-administer his/her medications.

Signature of parent/guardian **Date**

Youth's insurance carrier _____ Subscriber's name _____

Policy number/ID number _____ Other information: _____

Insurance company customer service phone # _____

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 my son/daughter, under the general or specific instructions of the on-call physician at a hospital or clinic. It is understood that this consent is given in advance of any specific diagnosis or treatment, and it 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.

I understand that any and all medical expenses incurred are my responsibility and that there is not medical insurance coverage provided by Old North Church, Marblehead, MA.

This consent will remain in effect for the church school year (September to September) unless otherwise specified.

Signature of parent/guardian **Date**