

**THE CONGREGATIONAL CHURCH OF SOUTH DARTMOUTH  
YOUTH GROUP MEDICAL RELEASE FORM**

Name of youth \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Name of parent/guardian \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

**HEALTH HISTORY** (Please check all that apply)

Vision/hearing impairment     Seizure disorders     Physical Disability  
 Asthma     Diabetes     Appliances (retainers, contact lenses, etc.)

Allergic to any medicines  No  Yes – List: \_\_\_\_\_

Allergic to any foods  No  Yes – List: \_\_\_\_\_

Other important medical information \_\_\_\_\_  
\_\_\_\_\_

Physician's name and phone number \_\_\_\_\_

Is your child taking a prescription or non-prescription medication?  No  Yes

If yes, please provide the following:

Medication \_\_\_\_\_ Dosage and frequency \_\_\_\_\_

Medication \_\_\_\_\_ Dosage and frequency \_\_\_\_\_

Medication \_\_\_\_\_ Dosage and frequency \_\_\_\_\_

Can your child be expected to take their 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

**PLEASE TURN OVER AND COMPLETE FORM**

Health insurance policy and number \_\_\_\_\_

Name of primary insured \_\_\_\_\_

**STATEMENT OF CONSENT**

I, the undersigned, parent/legal guardian of \_\_\_\_\_, do hereby consent to any x-ray, anesthetic, medical diagnosis or treatment and hospital services that may be rendered to said minor, under the general or specific instructions of \_\_\_\_\_ (name of youth's physician) or, if unavailable, to on-call physicians at hospital. 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 medical treatment.

This consent will remain effective until June of 2011. I understand that any and all medical expenses incurred are my responsibility and that there is not medical insurance coverage by The Congregational Church of South Dartmouth.

\_\_\_\_\_  
Signature of parent/guardian Date

Parent e-mail address: \_\_\_\_\_

Youth e-mail address: \_\_\_\_\_