

PLEASE COMPLETE BOTH SIDES OF FORM

PLEASE COMPLETE AND SIGN MEDICAL RELEASE ON REVERSE

**First Church of Christ, Old North Church
2016-2017 Youth Group Registration-Media Release-Medical Release Form**

PLEASE COMPLETE BOTH SIDES OF FORM

MEDICAL RELEASE

Youth's physician _____ Phone _____

Emergency contact _____ Phone _____

Youth's insurance carrier _____ Subscriber's name _____

Policy number/ID number _____ Other information: _____

Insurance company customer service phone # _____

Health history (please check all that apply):

_____ Frequent colds _____ Seizure disorder _____ Physical impairment

_____ Appliances (retainer, _____ Stomach aches _____ Diabetes
contact lenses, etc.) _____ Mental impairment _____ Asthma

_____ Sleep disturbances _____ Vision/hearing _____ Motion sickness

_____ Emotional disability _____ impairment _____ Behavioral problems

Allergies (describe) _____ Other (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 _____

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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

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