ELFINWILD PRESBYTERIAN CHURCH STUDENT MINISTRIES

3200 MT. ROYAL BLVD
GLENSHAW, PA 15116
(412) 486-5400

MEDICAL RELEASE FORM

I, the Parent/Guardian of_____, hereby authorize any and all medical treatment to be administered to the above named child in the case of illness, accident, injury, or emergency. I hereby authorize The Director of *Elfinwild Presbyterian Church Student Ministries*, or such substitute as may be designated, or such adult leader who is with the above named child during the illness, accident, injury or emergency, to act for me on my behalf, until such time that I may be contacted, as the person having the legal authority to act for the above named child in the procurement of medical treatment. I understand, as the Parent/Guardian, I am responsible for any and all medical costs. I understand, that *Elfinwild Presbyterian Church, Elfinwild Presbyterian Church Student Ministries*, their employees, officers, youth leaders, adult leaders and volunteers, the Director of Student Ministries, and other *Elfinwild Presbyterian Church* leadership will not be held liable for any illnesses, accidents, injuries, emergencies or damages incurred.

(please print when providing the information below)

Parent/Guardian's Name _____
Address_____
City_____State_____Zip Code_____
Home Phone (____)_____Work Phone(____)_____

If Unable to reach in emergency, notify:_____
Address_____
City_____State_____Zip Code_____
Phone #(____)_____Relationship_____

Family Doctor_____
Address_____
City_____State_____Zip Code_____
Phone #(____)_____

Health History

Child's Age_____ Date of Birth_____
Operations/Serious Injuries/Recurring Illnesses_____
Dietary Restrictions_____
Activity Restrictions:___YES___NO if YES, please explain_____
_____

Allergies

__Insect Stings __Heart Condition __Chronic Asthma __Diabetes
__Hay Fever __Nervous Disorder __Drugs __Other
Please provide details (reactions,treatments,etc.) to any items checked above:_____
_____
Date of last Tetanus Shot_____Name&Dosage of any medications being taken: _____

Health Insurance Coverage

Name of Insurance Company_____
Phone #(____)_____Policy Number_____
Insured's Name_____
Name and Address of Insured's Employer_____

Parent/Guardian's Signature_____**Date**_____