MEDICAL RELEASE FORM

MINOR CHILD

EFFECTIVE FOR ALL TRIPS AND/OR FUNCTIONS WITH THE SUNSET CHURCH OF CHRIST FOR THE YEAR OF ***2016-2017***

NAME: _____

ADDRESS: _____ BIRTHDATE: _____

PHONE NUMBER: _____ PARENT or GUARDIAN'S NAME: _____

MEDICAL INFORMATION

PHYSICIAN'S NAME and TELEPHONE #	DRUG ALLERGIES	CURRENT MEDICATIONS

LIST ALL PERTINENT MEDICAL PROBLEMS: _____

*** I give permission to dispense over the counter medications to my child: _____Yes _____ No**

IN CASE OF EMERGENCY, CONTACT:

NAME: _____ CELL PHONE: ( ) _____

HOME PHONE: ( ) _____ BUSINESS PHONE: ( ) _____

2ND CONTACT:

NAME: _____ CELL PHONE: ( ) _____

HOME PHONE: ( ) _____ BUSINESS PHONE: ( ) _____

MEDICAL INSURANCE INFORMATION:

POLICY HOLDER: _____ GROUP #/ POLICY # _____

INSURANCE CO.: _____

INSURANCE PHONE: ( ) _____

SUNSET CHURCH OF CHRIST MEDICAL INSURANCE: Accidental medical benefits are provided for members and guests while involved in any church sponsored event. The limit per person is $5,000.00. Organized sporting events and automotive related injuries are excluded. Automotive related injuries are provided for under the vehicle policy with a limit of $2,500.00 per person. There is no coverage under these policies for sickness whether sudden or not, unless caused by a covered accident.

MEDICAL RELEASE:

I understand that in the event medical treatment is required for the above-named MINOR, that every effort will be made to contact me (us). However, if I cannot be reached, I give my permission to the staff or sponsor of the Sunset Church of Christ to secure the services of a licensed physician to provide the care necessary, including anesthesia, for my child's well-being.

SIGNED: _____ DATE: _____

(Parent or Guardian)

Medical information for: _____ Age of child: _____
(Name of child)

Information provided by: _____
(Name of person completing form)

Please indicate if your child has ever been treated for the following conditions:

	YES	NO	Under Current Treatment?	Past Treatment? (Indicate Dates)	List Current Medications:
ADD or ADHD?					
Anxiety?					
Asthma?					
Allergies?					
Bleeding Disorders?					
Broken Bones? (Please indicate)					
Depression?					
Diabetes?					
Epilepsy?					
Fainting (unexplained)?					
GERD?					
Head Injury?					
Heart Problems? (Please indicate)					
Hypertension?					
Hypotension?					
Intestinal Problems?					
Psychiatric Problems?					
Seizures (of any kind)?					

Other:

_____

_____

COMMENTS OR DIRECTIONS FOR CARE:

_____

_____

_____

_____

_____

Signed: _____ Date: _____
(Parent must sign for a minor)