

# Children/Preschool Ministry Medical Release Form

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Sex: Male Female Birth Date: \_\_\_\_\_ Grade Completed: \_\_\_\_\_

Name(s) of Parent(s) or Guardian(s) : \_\_\_\_\_

Parent(s) or Guardian(s) Work Phone: \_\_\_\_\_

Emergency Contact if parents can not be reached : \_\_\_\_\_

Emergency Contact's Phone: \_\_\_\_\_

\_\_\_\_\_ has my permission to attend all church sponsored children/preschool events with the Eleventh Street Baptist Church (Upland, CA) between the dates of 10/1/06 and 12/31/06.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical Information

1. Has this student had any of the following? (Check if YES)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Recent illness                         | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Diabetes                   |
| <input type="checkbox"/> Heart Condition                        | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Epilepsy/Seizures  | <input type="checkbox"/> Unexplained weight loss    |
| <input type="checkbox"/> Immunity disorder                      | <input type="checkbox"/> Chronic cough   | <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Ear, nose, throat problems |
| <input type="checkbox"/> Allergies – if yes please list : _____ |  |   |   |

2. Immunizations : Date of last Tetanus shot \_\_\_\_\_  
Dates of Polio Vaccine 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

3. List any medications this student will need to take while at the events: \_\_\_\_\_

NOTE : All medications (prescription and non prescription) must be checked in to a counselor at each event. A counselor will administer all medications according to parents and/or Doctor's instructions.

4. List any instructions for the administering of the student's medication: \_\_\_\_\_

5. Restrictions: Any swimming restrictions? Yes No (circle)  
Other activity restrictions? Yes No (circle)  
Give details on the reverse side

6. To the best of your knowledge has this student been exposed to any communicable disease within the last 3 weeks? Yes No If yes please explain: \_\_\_\_\_

7. Medical Insurance: Company \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

8. Treatment authorization: With the understanding that due care for the health and safety of all participants will be exercised, Eleventh Street Baptist Church will not be held responsible in the event of any illness or accidental injury. I also authorize and direct the leaders to secure the services of properly qualified medical personnel to perform any necessary medical or surgical procedure for my child in the event of any illness or injury, with the understanding that every reasonable effort will be made to contact me before such action is taken. I also agree to assume all legal and financial responsibility for the treatment of my child.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent \_\_\_\_\_ Legal Guardian \_\_\_\_\_ (check one)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_