

This form is to be completed in black or blue ink by the minor's parent or legal guardian for Mountainview Community Christian Church.

Student Ministries Medical Release Form

September 2009 - August 2010

Student's Name: _____ Birth Date: ____ / ____ / ____ Sex: _____

Grade: _____ School: _____

Home Phone: (____) _____ Email: _____

Address: _____ City: _____ Zip: _____

Student Lives with: Mother Father Both Guardian

Father's Name: _____ Cell Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Mother's Name: _____ Cell Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Guardian's Name: _____ Cell Phone: (____) _____

Employer: _____ Work Phone: (____) _____

MEDICAL INFORMATION

Physician's Name: _____ Phone: (____) _____

Insurance Provider's Name: _____ Policy No.: _____

Please answer all questions regarding medical history and conditions on the other side of this form.

PARENTAL CONSENT TO TREAT A MINOR

Being the Parent/Legal Guardian of _____ (print minor's name), I _____ (parent/guardian's printed name) do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give my permission to the attending physician to treat my minor child. I further understand that the doctors, dentist, and other providers attending to my child will take reasonable safety precautions during their care.

Further, as parent or legal guardian I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care of treatment that is given to my child. Any policy of Mountainview Community Christian Church or organization sponsoring this event will be used as the secondary coverage.

Date: _____ Parent/Guardian Signature: _____

Notary Date: _____ Notary Signature: _____

Notary Seal/Stamp: _____

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Student Ministries Medical Release Form (continued)

HEALTH HISTORY (Check all that apply and supply appropriate dates)

Note: Vaccination dates are required if your student is to attend any overnight activities such as retreats, camps or missions trips.
Please fill in the most recent booster/vaccination date rather than attaching a separate document.

	Disease	Vaccination Date
<input type="checkbox"/> Ear Infection _____	<input type="checkbox"/> Hep B (Hepatitis B) _____	_____
<input type="checkbox"/> Heart Defect/Disease _____	<input type="checkbox"/> DTaP/Tdap _____	_____
<input type="checkbox"/> Convulsions/Epilepsy _____	<input type="checkbox"/> DT/Td _____	_____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Hib _____	_____
<input type="checkbox"/> Bleeding/Clotting Disorders _____	<input type="checkbox"/> IPV/OPV (Polio) _____	_____
<input type="checkbox"/> Hypertension/ADD _____	<input type="checkbox"/> MMR _____	_____
<input type="checkbox"/> Mononucleosis _____	<input type="checkbox"/> Varicella (Chickenpox) _____	_____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Hep A (Hepatitis A) _____	_____

ADDITIONAL MEDICAL INFORMATION/INSTRUCTIONS (please list below)

MEDICATIONS

Name: _____

Dosage: _____

Frequency: _____ Duration: _____

Any Side Effects: No Yes; please list: _____

Name: _____

Dosage: _____

Frequency: _____ Duration: _____

Any Side Effects: No Yes; please list: _____

May we give your student Advil or Tylenol if needed: Yes No

ALLERGIES (please include food, drug, and other allergies)

ACTIVITY RESTRICTIONS
