FAITH FELLOWSHIP STUDENT MINISTRY MEDICAL RELEASE FORM

Name: _____

BIRTH DATE: _____ SOCIAL SECURITY: _____

ADDRESS: _____ ZIP:_____

HOSPITAL INSURANCE:

COMPANY: _____

POLICY NUMBER: _____

GROUP/CERTIFICATE NUMBER: _____

NAME OF INSURED: _____

IMMUNIZATIONS: DATE OF LAST TETANUS: _____

LIST KNOWN ALLERGIES, INCLUDING ALLERGIES TO MEDICATIONS:

MEDICATION: _____ REASON: _____

MEDICATION: _____ REASON: _____

WHAT MEDICATIONS CAN BE ADMINISTERED TO YOUR CHILD IF NEEDED?

[ ] ASPIRIN [ ] IBURPOFEN [ ] TYLENOL [ ] OTHER

PLEASE LIST ANY OTHER INFORMATION WE MIGHT NEED TO BE AWARE OF REGARDING THE PHYSICAL CONDITION OF YOUR CHILD?

PERSON(S) TO BE CONTACTED IN THE EVENT OF AN EMERGENCY:

NAME: _____ PHONE: (H) _____ (W) _____

NAME: _____ PHONE: (H) _____ (W) _____

PLEASE LIST ONE PERSON WHO CAN BE CONTACTED IF PARENT CANNOT BE REACHED:

NAME: _____ PHONE: (H) _____ (W) _____

TO ATTENDING PHYSICIAN(S)

PERMISSION IS HEREBY GRANTED FOR YOU AT THE DISCRETION OF THE YOUTH COUNSELORS OF FAITH FELLOWSHIP CHURCH, JOHNSTOWN, OH... TO PERFORM WHATEVER CARE IS NECESSARY FOR THE WELFARE OF MY (OUR) SON/DAUGHTER UNTIL SUCH TIME AS YOU ARE ABLE TO REACH ME (US) PERSONALLY.

DATE: _____

DATE: _____

SIGNATURE OF PARENT (S) _____ _____

STUDENTS WHO FAIL TO COMPLY WITH ANY EXPECTATIONS MAY BE SENT HOME AT THEIR PARENTS EXPENSE.