MEDICAL RELEASE FORM: Multiple Event & Activities Release

____ ______/______/__________

Name Date of Birth

I, as parent or legal guardian of the person named above, do hereby give my permission for the adult leaders of St. Paul's U.C.C. to act on my behalf for any and all medical needs that my child might require while participating in Youth Ministry and/or Christian Education events. I understand that, in the event of a medical emergency where treatment is necessary, every effort will be made to contact me. However, if I cannot be reached, I give my permission to the leaders of St. Paul's U.C.C. to secure a licensed physician to provide the care necessary, including medical transportation, anesthesia, tests, x-rays, and injections, for my child's well being. Further, I grant permission to the leaders of St. Paul's U.C.C. to administer prescribed & over the counter medications as needed. I give permission to the physician selected by the leaders of St. Paul's U.C.C. to secure and administer treatment, including hospitalization, for the person named above. I agree to assume any financial responsibility for my child's care & agree to the release of any records necessary for treatment or insurance purposes.

I understand that if any modifications are needed to this form due to changes in insurance information, medical needs, or any other reason throughout the course of the above period of time, it is my responsibility to notify the leadership of St. Paul's U.C.C. and provide a completed replacement form.

____ ______/______/__________

Signature of parent/guardian Date

Home phone ________________________________ Mobile phone ________________________________

Work phone ________________________________ Email address ________________________________

Home Address ____

Emergency Contact(s):

Main contact ____ Relationship ______________________

Main Phone __________________________________ Alternate Phone _________________________________

Secondary contact ____ Relationship ______________________

Main Phone __________________________________ Alternate Phone _________________________________

Physician(s)

Primary Doctor ______________________________________ Phone Number _________________________

Other Physicians (specify specialty) ____

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Insurance Information

Insurance Company ________________________________ Employer ____________________________

Policy Number(s) ____

Name of Insured _______________________________ Relationship to participant __________________

SSN of Insured* __________________________ SSN of Participant* ______________________________

Is preauthorization needed? Yes No Contact number ___________________________________

*SSN is optional based on personal comfort levels. Care providers often request this information, but have never refused treatment if we did not have it.

Medical Information

Please list any medical conditions of which the group leaders or an emergency care physician should be aware (i.e. but not limited to surgeries, asthma, allergies, chronic illnesses, heart condition, epilepsy, diabetes)

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At the present time, is this person under a physician's care? YES NO If "Yes," please describe

____

____

Is this person taking any medication? YES NO If "YES," list names, dosage, and any side effects

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____

May your child take the following medications?

Lomotil (for diarrhea)	Yes	No	Tylenol	Yes	No
Advil	Yes	No	Pepto-Bismol	Yes	No

Please list any other allergies to medications and/or restrictions ____________________________________

____

Please list any limits on physical activity or other special instructions ______________________________

____

____

Blood type (if known) ______

Please include copies (front & back) of medical insurance & prescription cards.