

# Maple City Chapel Youth Group

## Demographic Info, Health History, Medical Release, and Consent Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Gender: M / F

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

Home Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Text: Y or N

Email Address: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Dad's Name: \_\_\_\_\_ Dad's Cell Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Text: Y or N

Dad's Email Address: \_\_\_\_\_ Dad's Work Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mom's Name: \_\_\_\_\_ Mom's Cell Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Text: Y or N

Mom's Email Address: \_\_\_\_\_ Mom's Work Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation to you: \_\_\_\_\_

Home Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Business Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

### Consent Form

I understand that video and photos may be taken of my child at youth group events and I agree that photos/videos may be used in public venues, including but not limited to the church website and Facebook.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

### Health History & Medical Release

Check all that apply below:

#### Conditions

High Blood Pressure \_\_\_\_\_

Heart Defects/Disease \_\_\_\_\_

Asthma \_\_\_\_\_

Epilepsy \_\_\_\_\_

Diabetes \_\_\_\_\_

#### Allergies

Food \_\_\_\_\_

Animal(s) \_\_\_\_\_

Medicine \_\_\_\_\_

Insect Sting \_\_\_\_\_

Hay Fever \_\_\_\_\_

Please explain any condition or allergy checked above.

List with date any major illness, injury, or surgery.

Is youth currently under any physician's care for a medical or psychological problem?

List any medications currently being taken and reason for their use.

Are vaccinations up-to-date? If not, please explain.

Date of last tetanus booster: \_\_\_/\_\_\_/\_\_\_

### Authorization for Medical Care

I hereby certify that the above information is correct and give permission for the release of these medical records in the event of illness or injury. I give permission to the youth sponsors to perform treatment for minor injuries. I also give permission for the youth sponsors to transport my child to or from a doctor and/or hospital for medical treatment. Furthermore, I give permission for the sponsors to allow hospital personnel and/or a licensed physician to perform emergency treatment and inject and/or administer drugs in conjunction with such emergency treatment.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_