Immanuel Lutheran Church Missouri Synod

210 South Charles Street Westfield, Wisconsin 53964

MEDICAL RELEASE FORM

Youth's Full Name_____
Date of Birth: _____ Grade in School _____

Parents'/Guardian Name _____

Home Address: _____

Street City Zip code

Home phone _____ Youth Cell _____

Mom Cell _____ Mom Work _____

Dad Cell _____ Dad Work _____

Youth Email _____

Parent's/Home Email _____

Consent and Release From Liability

Please fill out the Emergency Medical Information form regarding your child's health so that we might be informed of important health issues in case of an emergency.

(I) (We), the undersigned parent(s) and/or natural guardians(s) of _____, a minor, do hereby authorize my child's youth leaders to (1) consent to medical, surgical and dental care for such minor child, (2) consent to any diagnostic tests, medical, surgical or dental procedure of treatment as may be considered therapeutically necessary by the physician, surgeon, dentist, nurses and other health care personnel as may be deemed necessary for such minor child, admit such minor child to any hospital, clinic, emergency room, laboratory or other health care or diagnostic facility for examination, treatment, surgery or care and sign all necessary consents and authorizations, and (3) consent to transportation provided.

I understand that an attempt will be made to notify the parent(s)/guardian(s) first. If parent(s)/guardians(s) are not available, however, the above authorizations will take place.

Signatures

_____ Date: _____
Parent/Legal Guardian

_____ Date: _____
Parent/Legal Guardian

Insurance Information

Health Insurance Company: _____
Insurance Policy Number: _____
Insurance Company Phone Number _____
Primary Physician: _____Phone: _____
Primary Dentist: _____ Phone: _____

Medical Information Sheet

Which of the following may be administered to your child? (Check all that apply)
___Aspirin ___Ibuprofen (i.e. Advil) ___Acetaminophen (i.e. Tylenol)
General: Does participant have: (if "yes" explain)
____ Yes ____ No Allergies? _____
____ Yes _____No Heart Condition?_____
____ Yes _____No Other? _____
Is participant subject to: (if "yes" explain)
____ Yes ____No Headaches? _____
____ Yes ____ No Seizures?_____
____ Yes ____ No Motion Sickness? _____
____ Yes ____ No Fainting? _____
____ Yes ____ No SleepWalking? _____
_____Yes ____ No UpsetStomach? _____
Does participant have reaction to: (if "yes" explain)
____ Yes ____ No BeeSting? _____
____ Yes ____ No Penicillin?_____
____ Yes ____ No OtherDrugs? _____
____ Yes ____ No PoisonIvy,Oak,Sumac? _____
____ Yes ____ No Other? _____
____ Yes ____ No Are any drugs ineffective in treatment? _____
____ Yes ____ No Is the participant diabetic?
____ Yes ____ No Does the participant have any sight or hearing impairment?
____ Yes ____ No Does the participant wear contact lenses?

Emergency Contacts (please provide 2)

Emergency Contact Name #1_____

Relationship to Youth:_____ Phone: _____

Emergency Contact Name #2 _____

Relationship to Youth: _____ Phone: _____

Medical Form effective date _____ end date 08/31/2016