Youth Ministries **Medical Release Form**

Effective dates: _____ to _____

Please print in ink

Name: _____Age _____ Birthday_____
LAST FIRST MIDDLE

Year in school _____ ☐ Male ☐ Female Email _____

Address _____ City_____ State_____ Zip_____

Phone _____

Medical insurance company_____ Policy #_____

Spouse's name _____ Phone: Home_____ Work_____

Emergency contact_____ Phone: Home_____ Work_____

Physician _____Office phone _____

Dentist _____Office phone _____

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this person. If necessary, add another page with details:

1. Do you have allergies to:
   ☐ pollens ☐ medications ☐ food ☐ insect bites

2. Do you suffer from, or have you ever experienced any of the following:
   ☐ asthma ☐ epilepsy / seizure disorder ☐ heart trouble ☐ diabetes
   ☐ frequently upset stomach ☐ physical handicap

3. Date of last tetanus shot:_____
4. Does you wear ☐ glasses ☐ contact lenses
5. Please list and explain any major illnesses you experienced during the last year:

   Additional comments:

   Should your activities be limited for any reason? Please explain: