

# Grace Community Church @ Deerfoot

## Medical Information & Release Form

*Please print in black or blue ink*

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_

Parents' Names \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Work # \_\_\_\_\_ E-mail: \_\_\_\_\_

### Medical Information

Subject to:	Yes	No	Now Have or Have Had	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		
Wearing Corrective lenses?			Do you walk in your sleep?		
Is hearing good?					

Please explain "yes" answers:

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Please include any additional remarks and special instructions to better assist emergency service personnel: \_\_\_\_\_

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Please list all current medications:

Name of Medication	Dosage	Times Taken

Date of last Tetanus Vaccination: \_\_\_\_\_

Please check over-the-counter medications that may be administered:

- Tylenol       Ibuprofen       Cough Syrup       Decongestant  
 Dramamine    Antacid             Polysporin         Hydrocortisone  
 Other: \_\_\_\_\_

Please identify allergies including allergies to food, medications, and drug reactions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have any other medical/special needs of which we need to be aware:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***Please inform us of any changes during the year concerning your youth's medical needs.***

### Please attach a copy of your medical insurance card (front & back)

In the event of an emergency where medical treatment is required, I give my permission to the church staff or leader to obtain the services of a licensed physician. Please attempt to notify me immediately concerning any such emergency.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_