# Medical Form

## Basic Information

**Full name of participant:**_____ **DOB:**_____/_____/_____ **Age:**_____

**Grade completed:**_____ ☐ Male ☐ Female Participant's contact #:_____

Name of parent(s) or guardian(s):_____
Primary phone #:_____ Secondary phone #:_____
Address:_____ City:_____ State:_____ Zip:_____

Emergency contact:_____ Phone #:_____
Relationship to participant:_____
Physician:_____ Office phone:_____
Dentist:_____ Office phone:_____

## Medical Information

Does your student suffer from, or has ever experienced, or is being treated currently for any injury or sickness (including asthma, epilepsy, heart trouble, diabetes, upset stomach, etc.)? ☐ yes ☐ no

If yes, please explain:_____
_____

Is your youth currently taking any prescription or non-prescription medication? ☐ yes ☐ no

If yes, please list medication name(s) and dosage(s):

_____
_____
_____

Does your youth have, or has your youth ever had, any of the following?

☐ asthma ☐ epilepsy/seizure disorder ☐ heart trouble ☐ diabetes ☐ seizures
☐ frequently upset stomach ☐ physical handicap ☐ kidney disease ☐ other

Explain:_____
_____

For your student's safety and our knowledge, is your student a –

☐ good swimmer ☐ fair swimmer ☐ non-swimmer

Does your student have allergies to –

☐ pollens/plants ☐ medications ☐ food ☐ insect bites ☐ other_____

Explain (including nature/severity of reaction & preferred method of treatment):

_____

If your student will be carrying an Epi Pen, does he/she know how to administer it? ☐ yes ☐ no

Does your student wear: ☐ glasses ☐ contacts

Does your student ever sleepwalk: ☐ yes ☐ no If so: ☐ frequently ☐ infrequently

Date of last tetanus shot:_____ Blood type (if known): _____

Should this student's activities be restricted for any reason (physical handicap, parent/guardian preference, etc.)? ☐ yes ☐ no If yes, please explain:_____

_____

Please list and explain any major illnesses the student experienced during the past year:

_____

_____

Should my student develop a condition requiring minor medical treatment (including, but not limited to: allergies, cough, upset stomach, headache, etc.), I authorize the adult(s) in charge to issue my student the prescribed dosage of the following medications:

☐ Tylenol (acetaminophen) ☐ Advil (ibuprofen) ☐ Cortaid (hydrocortisone cream)
☐ Benadryl (antihistamine) ☐ Sudafed **(**decongestant) ☐ Tums (antacid)
☐ Halls Cough Drops (cough suppressant) ☐ Other:_____

*If you anticipate that your student will need an over-the-counter medication while he/she is participating in a youth function, this medication should be sent with the student and listed above.*

## Insurance Information

Insurance Company:_____ Policy or Group #:_____

Name of Insured:_____ Relationship to Participant:_____

## Medical/Liability Release

**THIS CONSENT FORM GIVES PERMISSION TO SEEK WHATEVER MEDICAL ATTENTION IS DEEMED NECESSARY, AND RELEASES SHEPHERD OF THE HILLS LUTHERAN CHURCH/SUMMER SERVE AND ITS STAFF OF ANY LIABILITY AGAINST PERSONAL LOSSES OF NAMED CHILD. I/WE THE UNDERSIGNED HAVE LEGAL CUSTODY OF THE STUDENT NAMED ABOVE, A MINOR, AND HAVE GIVEN OUR CONSENT FOR HIM/HER TO ATTEND EVENTS BEING ORGANIZED BY SHEPHERD OF THE HILLS LUTHERAN CHURCH/SUMMER SERVE. I/WE UNDERSTAND THAT THERE ARE INHERENT RISKS INVOLVED IN ANY MINISTRY OR ATHLETIC EVENT, AND I/WE HEREBY RELEASE SHEPHERD OF THE HILLS LUTHERAN CHURCH, ITS PASTORS, EMPLOYEES, AGENTS, AND VOLUNTEER SUMMER SERVE WORKERS FROM ANY AND ALL LIABILITY FOR ANY INJURY, LOSS, OR DAMAGE TO PERSON OR PROPERTY THAT MAY OCCUR DURING THE COURSE OF MY/OUR CHILD'S INVOLVEMENT. IN THE EVENT THAT HE/SHE IS INJURED AND REQUIRES THE ATTENTION OF A DOCTOR, I/WE CONSENT TO ANY REASONABLE MEDICAL TREATMENT AS DEEMED NECESSARY BY A LICENSED PHYSICIAN. IN THE EVENT TREATMENT IS REQUIRED FROM A PHYSICIAN AND/OR HOSPITAL PERSONNEL DESIGNATED BY THE CHURCH, I/WE AGREE TO HOLD SUCH PERSON FREE AND HARMLESS OF ANY CLAIMS, DEMANDS, OR SUITS FOR DAMAGES ARISING FROM THE GIVING OF SUCH CONSENT. I/WE ALSO ACKNOWLEDGE THAT WE WILL BE ULTIMATELY RESPONSIBLE FOR THE COST OF ANY MEDICAL CARE SHOULD THE COST OF THAT MEDICAL CARE NOT BE REIMBURSED BY THE HEALTH INSURANCE PROVIDER. FURTHER, I/WE AFFIRM THAT THE HEALTH INSURANCE INFORMATION PROVIDED ABOVE IS ACCURATE AT THIS DATE AND WILL, TO THE BEST OF MY/OUR KNOWLEDGE, STILL BE IN FORCE FOR THE STUDENT NAMED ABOVE. I/WE ALSO AGREE TO BRING MY/OUR CHILD HOME AT MY/OUR OWN EXPENSE SHOULD THEY BECOME ILL OR IF DEEMED NECESSARY BY THE STUDENT MINISTRIES/SUMMER SERVE STAFF MEMBER.**

Signature of Parent or Guardian: _____ Date:_____

Effective dates: June 7-10, 2018