

MEDICAL INFORMATION

Student's Name _____ Birth Date ____ / ____ / ____

Address _____ Zip _____ Male Female

Grade (if summer, put grade as of upcoming Fall) _____ Student cell phone _____

Parent email _____ Student email _____

Parent's Names and Contact Numbers

_____ Home Phone _____ Cell Phone _____

_____ Home Phone _____ Cell Phone _____

Emergency Contacts OTHER Than Parents

_____ Phone _____

_____ Phone _____

Doctor _____ Phone _____

Dentist _____ Phone _____

Allergies (include drugs) _____

List all prescriptions drugs taken on a regular basis/dosage/how often taken:

Date of last tetanus shot _____

Hospital admissions: Date and reason _____

Does student have any health problems or chronic medical conditions?

HEALTH INSURANCE INFORMATION

Employee Name: _____ Employer _____

Policy # _____ Group Number _____

Phone Number to verify coverage _____ (please provide a copy of insurance card)

Parent's Signature (please sign in ink) _____

PLEASE COMPLETE FRONT & BACK

I/we, _____ the parent(s) of _____

do hereby give over and release unto the staff and chaperones of University United Methodist Church all authority and responsibility to authorize any and all medical treatment necessary for the protection of the health and well being of my aforementioned child. This authorization shall authorize any and all medical treatment licensed medical personnel, pursuant to the express authorization, whether written or oral, of the above-mentioned representatives. I hereby release University United Methodist Church, its staff, chaperones, and volunteers from any and all claims and liabilities of whatsoever nature, both individually and collectively, that may arise from my child's participation in this event. This authorization shall be effective on _____ inclusive or until it is expressly revoked.

(today's date)

Parent Signature (please sign in ink)

PLEASE COMPLETE FRONT & BACK