CONFIDENTIAL

EMERGENCY TREATMENT, MEDICAL RELEASE, HISTORY FORM

(Form will be held in secured storage by Director of Family Minister)

Please fill out the information below AS COMPLETELY AS POSSIBLE about the participant.

Child's Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

School: _____ Grade: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

_____ _____

Daytime Phone:_____ Daytime Phone:_____

Evening Phone: _____ Evening Phone: _____

Email: _____ Email: _____

Medical Insurance Company:_____

Policy/Group Number _____

Name of Insured: _____ Ins. Phone Number _____

Name of Physician: _____ Phy. Phone Number _____

Health History - please circle Yes or No include date and notes as needed

Item	**Yes**	**No**	**Date / Notes**
Allergies	Yes	No	
Seasonal Asthma	Yes	No	
Foods	Yes	No	
Ear Infections	Yes	No	
Insect Stings	Yes	No	
Diabetes	Yes	No	
Plants	Yes	No	
Seizures	Yes	No	
Drugs	Yes	No	
Heart Disease	Yes	No	
Kidney Disease	Yes	No	
Other (Specify)	Yes	No	

Additional Notes:

_____

Medication presently being taken:

_____

Date of Last Tetanus Shot:_____(Year will suffice)

Over the counter medication authorization: I hereby give permission for my son/daughter to use the following over the counter medications (OTC) and/or their generic equivalents as directed on the label. (Check Yes or No for each Medication)

Advil (Ibuprofen)	Yes	No	Cough Drops	Yes	No
Tylenol (Acetaminophen)	Yes	No	Pepto-Bismol / Maalox / Tums	Yes	No
Decongestant	Yes	No	Dramamine	Yes	No
Benadryl	Yes	No	Neosporin	Yes	No
Calamine Lotion	Yes	No	Hydrocortisone	Yes	No

List any additional medications your child MAY NOT HAVE:

Emergency Authorization: I hereby give permission to the medical personnel selected by the SCPC at PH adult in charge to order X-Rays, routine tests, and treatment for my child, and in the event I can't be reached in an emergency, I hereby give permission to the physician selected by the adult in charge to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

If I/We cannot be reached in the event of an emergency, the following person is authorized to act in my behalf:

_____

Name Relationship Phone

I know of no reason(s), other than the information on this form, why my child should not participate in SCPC at PH program activities. I acknowledge that the information on both sides of this form is correct, and I will inform SCPC at PH if any part of this information changes.

_____

Parent/Guardian Signature Print Name Date