

St. John's Lutheran Church Medical Release/Consent Form 2007-2008

Student's Name: _____ Age: _____ Grade: _____ DOB: _____

Address: _____

Home Phone: _____ Student's Cell: _____

Mother's Contact Information:

Name: _____ Cell: _____ Work: _____

Address: _____

Home Phone: _____

Father's Contact Information:

Name: _____ Cell: _____ Work: _____

Address: _____

Home Phone: _____

Emergency Contact Information:

Name: _____ Cell: _____ Work: _____

Address: _____

Home Phone: _____ Relationship to Student: _____

Medical Information:

Health Plan Carrier: _____ Policy Number: _____

Policy Holder: _____ Relationship to Policy Holder: _____

Family Doctor: _____ Office Phone: _____

Family Dentist: _____ Office Phone: _____

Consent:

I hereby release St. John's Lutheran Church, its staff and sponsors, from responsibility and liability for any injury or illness that my child may sustain during an activity occurring between August 2007 and August 2008. In the event of an emergency, I hereby authorize an adult leader of such activity, as agent for me, to consent to any x-ray, examination, medical, dental, or surgical diagnosis, treatment and hospital care advised or supervised by a physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered. I expect to be contacted as soon as possible. In addition, I agree that photos of student activities containing my child can be published in printed materials and the Student Ministry web page.

Signature of Parent/Legal Guardian

Date

The above signature has been attested to before me, a notary public, in and for _____ County of the State of Illinois, this _____ day of _____, 2007.

Notary Public

Emergency Medical History:

Does student have?

Allergies: No ____ Yes: _____

Heart Condition: No ____ Yes: _____

Other: _____

Is student subject to?

Headaches: No ____ Yes: _____

Seizures: No ____ Yes: _____

Motion Sickness: No ____ Yes: _____

Fainting: No ____ Yes: _____

Sleep Walking: No ____ Yes: _____

Upset Stomach: No ____ Yes: _____

Does Student have reactions to:

Bee Stings: No ____ Yes: _____

Penicillin: No ____ Yes: _____

Other Drugs: No ____ Yes: _____

Poison Ivy, Oak, Sumac: No ____ Yes: _____

Other: _____

Has your student had any serious illness or surgery within the past ten years?

No ____ Yes: _____

Does your student have any condition that would prevent him/her from participating in any activities? No ____ Yes: _____

Are any drugs ineffective in treatment? No ____ Yes: _____

Is your student Diabetic? No ____ Yes: _____

Does your student have any sight or hearing impairment? No ____ Yes: _____

Does your student wear contacts? No ____ Yes: _____

Date of last tetanus shot: _____

(Please make sure your student has a current tetanus shot!)

Please indicate anything else that the leaders should know to help avoid or deal with any situation that might arise: _____
