Medical Release and Permission Form

(Please print in ink)

Activity Effective dates: August 1, 2014 to September 1, 2015

Name: ____
LAST FIRST MIDDLE

Age: ____ **DOB:** ________ **Year in school:**________________ ☐ **Male** ☐ **Female**

Address: ____

City:_________________ **State:** ______ **Zip:** ___________

Phone: (___)____________ **Pager/cell:** (___)____________**E-mail:**______________________

Medical insurance company:______________________________**Policy#:**______________

Mother's name: ____

Phone: Home: (___)__________ **Work:** (___)______________ **Cell:** (___)______________

Father's name: ____

Phone: Home: (___)__________ **Work:** (___)______________ **Cell:** (___)______________

Emergency contact:____

Phone: Home: (___)__________ **Work:** (___)______________ **Cell:** (___)______________

Physician: _______________________________________ **Office phone:**______________

Dentist: ____ **Office phone:**______________

Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this student. If necessary, add another page with details:

1. For your child's safety and our knowledge, is your student a:
   ☐ good swimmer ☐ fair swimmer ☐ non-swimmer
2. Does your child have allergies to:
   ☐ pollens ☐ medications ☐ food ☐ insect bites
   If so, please list which ones:____
   ____
   ____
3. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:
   ☐ asthma ☐ epilepsy/seizure disorder ☐ heart trouble ☐ frequently upset stomach
   ☐diabetes ☐ physical handicap
4. Date of last tetanus shot: ____________________________
5. Does your child wear
   ☐ glasses ☐ contact lenses
6. Please list and explain any major illnesses the child experienced during the last year:____
   ____Additional comments:____

Should this child's activities be restricted for any reason? Please explain:_____________________
____
____

For your information, we expect each student to conform to these rules of conduct

-No possession or use of alcohol, drugs, or tobacco.
-No students can drive.
-No fighting, weapons, fireworks, lighters, or explosives.
-No offensive or immodest clothing.
-No boys in girls' sleeping quarters and no girls in boys' sleeping quarters.
-Participation with the group is expected.
-Respect property, one another, staff, and adult leaders and comply with event schedules.

Students who fail to comply with these expectations may be sent home at their parents' expense.

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

Student signature: _________________________________ Date: ______

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases Chaos Youth Ministry 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 participate in events being organized by Chaos Youth Ministry. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release Chaos Youth Ministry, its directors, employees, counselors, and other volunteer 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 Chaos Youth Ministry, 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 staff member.

Parent/guardian signature:____ Date: _________

THIS FORM MUST BE NOTARIZED

State of Arizona, County of Yavapai

On this ______ day of ____________________, 20____, before me personally appeared __________________________________, whom I know personally to be a person whose identity was proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this document, and acknowledged that he/she signed the above document.

(seal)

____
Notary Public