

# MEDICAL RELEASE FORM

## MINOR CHILD

EFFECTIVE FOR ALL TRIPS AND/OR FUNCTIONS WITH THE ADVENTURES IN MISSIONS PROGRAM FOR THE YEAR OF \_\_\_\_\_.

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_ PARENT or GUARDIAN'S NAME: \_\_\_\_\_

### MEDICAL INFORMATION

PHYSICIAN'S NAME and TELEPHONE #	DRUG ALLERGIES	CURRENT MEDICATIONS

LIST ALL PERTINENT MEDICAL PROBLEMS: \_\_\_\_\_

\* I give permission to dispense over the counter medications to my child:  Yes  No

### IN CASE OF EMERGENCY, CONTACT:

NAME: \_\_\_\_\_ CELL PHONE: (    ) \_\_\_\_\_  
HOME PHONE: (    ) \_\_\_\_\_ BUSINESS PHONE: (    ) \_\_\_\_\_

### 2ND CONTACT:

NAME: \_\_\_\_\_ CELL PHONE: (    ) \_\_\_\_\_  
HOME PHONE: (    ) \_\_\_\_\_ BUSINESS PHONE: (    ) \_\_\_\_\_

### MEDICAL INSURANCE INFORMATION:

POLICY HOLDER: \_\_\_\_\_ GROUP #/ POLICY # \_\_\_\_\_  
INSURANCE CO.: \_\_\_\_\_  
INSURANCE PHONE: (    ) \_\_\_\_\_

*SUNSET CHURCH OF CHRIST MEDICAL INSURANCE:* Accidental medical benefits are provided for members and guests while involved in any church sponsored event. The limit per person is \$5,000.00. Organized sporting events and automotive related injuries are excluded. Automotive related injuries are provided for under the vehicle policy with a limit of \$2,500.00 per person. There is no coverage under these policies for sickness whether sudden or not, unless caused by a covered accident.

### MEDICAL RELEASE:

I understand that in the event medical treatment is required for the above-named MINOR, that every effort will be made to contact me (us). However, if I cannot be reached, I give my permission to the staff or sponsor of the Adventures in Missions Program to secure the services of a licensed physician to provide the care necessary, including anesthesia, for my child's well-being.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Parent or Guardian)

## MINOR Child Medical Release Form - Page 2 of 2

Medical information for: \_\_\_\_\_ Age of child: \_\_\_\_\_  
(Name of child)

Information provided by: \_\_\_\_\_  
(Name of person completing form)

**Please indicate if your child has ever been treated for the following conditions:**

	YES	NO	Under Current Treatment?	Past Treatment? (Indicate Dates)	List Current Medications:
ADD or ADHD?					
Anxiety?					
Asthma?					
Allergies?					
Bleeding Disorders?					
Broken Bones? (Please indicate)					
Depression?					
Diabetes?					
Epilepsy?					
Fainting (unexplained)?					
GERD?					
Head Injury?					
Heart Problems? (Please indicate)					
Hypertension?					
Hypotension?					
Intestinal Problems?					
Psychiatric Problems?					
Seizures (of any kind)?					

Other: \_\_\_\_\_  
 \_\_\_\_\_

**COMMENTS OR DIRECTIONS FOR CARE:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signed: \_\_\_\_\_  
(Parent must sign for a minor)

Date: \_\_\_\_\_