

**MEDICAL RELEASE FORM
PERMISSION SLIP**

Please notify us if any changes in the following information occurs.

MEDICAL INFORMATION FOR JAN 1, 2010-FEB 1, 2011

NAME _____ SS# _____
ADDRESS _____ BIRTH DATE _____
PHONE _____ SCHOOL _____

MEDICAL INFORMATION

PLEASE CHECK AND SPECIFY IF ANY PAST HISTORY OF:

(Please give details-use the back of more space is needed)

___ ALLERGIES (food, drug, etc.) ___ ASTHMA ___ DIABETES
___ HEART CONDITION ___ HYPOGLYCEMIA ___ PHYSICAL DISABILITY
___ STOMACH UPSETS OR DISORDER (including car sickness)
___ REGULAR MEDICAL PRESCRIPTIONS (please specify)
OTHER(Please specify) _____
OTHER COMMENTS _____

ANY ACTIVITIES THAT STUDENT CANNOT PARTICIPATE IN _____

PERMISSION FOR THE CHURCH LEADER TO ADMINISTER:

(Upon request and demonstrated need) ___ ASPIRIN ___ TYLENOL ___ IBUPROFEN
___ OTHER OVER THE COUNTER MEDICATIONS (Please specify which-i.e. Benadryl,
Actifed, etc.) _____

___ PRESCRIPTION MEDICATION (Please specify prescription; when taken, how much, etc.)

NOTE: ALL medication should be given to the leader on Church activities

PARENT/GUARDIAN INFORMATION

NAME _____ HOME PHONE _____
ADDRESS _____ WORK PHONE _____

NAME OF CLOSEST RELATIVE _____ PHONE _____
FAMILY PHYSICIAN _____ PHONE _____
MEDICAL INSURANCE CARRIER _____ PHONE _____
MEDICAL CARD ID# _____ POLICY HOLDER _____

