

Westminster Chapel Medical History Release Form

Expires: December 31, 2011

***NOTE: WE WILL NOT ALLOW MINORS TO PARTICIPATE IN ANY ACTIVITIES WITHOUT THIS FORM COMPLETED & SIGNED,
ALONG WITH A COPY (BOTH SIDES) OF YOUR INSURANCE CARD.**

Full Name: _____ (include middle name) Birthdate: _____ High School Jr. High

School: _____ Age: _____ Current Grade: _____ Male Female

Names of Parents or Legal Guardians: (Father:) _____ (Mother:) _____

Address: _____ City _____ Zip _____

Home Phone: _____ Father's Work/Cell: _____ Mother's Work/Cell: _____

Emergency contact name (other than parent): _____ Relation to child: _____

Address: _____ Phone: _____

Doctor's name: _____ Address: _____

My son/daughter has had a physical within the last two (2) years: Yes No Phone: _____

Operations or serious injuries: _____

Indicate if your son/daughter has been immunized against the following (include dates if possible):

Childhood immunizations up to date (DPT yes _____ no / Polio yes _____ no / HIB yes _____ no / MMR yes _____ no)

If no, please explain: _____

Date of last tetanus booster: _____ **Name and dosage of any medication that must be taken (indicate frequency):** _____

Permission for camp nurse, counselor, or other adult staff to give Tylenol or Advil: Yes No

If the participant has had in the past, or now has, any of the following diseases or health problems, please check the appropriate line. FAILURE to check a line is an affirmation that he/she has not had, or presently does not have, that particular problem or disease.

- | | | |
|--|--|--|
| <input type="checkbox"/> Convulsions/ high temperature | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food or environment allergy (_____) |
| <input type="checkbox"/> Epilepsy or similar disease | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Medication allergies (_____) |
| <input type="checkbox"/> Nose bleeding sensitivity | <input type="checkbox"/> High temperature when ill | <input type="checkbox"/> Bee sting allergy |
| <input type="checkbox"/> Stomach upsets | <input type="checkbox"/> Fainting | <input type="checkbox"/> Other medical condition (specify below) |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Emotional/Learning difficulties | <input type="checkbox"/> Asthma or respiratory problems |

Physical conditions/symptoms that need special attention: _____

List any activity restrictions (including swimming, etc.): _____

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (BOTH SIDES) TO THIS FORM. IN A MEDICAL EMERGENCY, WITHOUT A PARENT PRESENT, THE INSURANCE CARD IS A MUST FOR YOUR CHILD TO RECEIVE CARE.

Insurance Company: _____ **Holder of the insurance:** _____

Policy #: _____ **Insured's ID #:** _____

Medical Release: The undersigned hereby consents to the administration of any and all medical, dental and surgical examinations or operations and treatment of all other related care, including the administration of drugs, tests, injections, anesthesia and/or blood transfusions to the above named minor that may be ordered by the physician and/or dentist in attendance at the medical center deemed necessary for emergency treatment. I hereby consent to the release of the medical report(s) to any doctor or agency for the admission of the above named minor to the hospital.

PARENT OR LEGAL GUARDIAN'S SIGNATURE

DATE

Photo Release: I hereby give my permission for the staff of Westminster Chapel to use my child's picture for fliers, videos, and the Westminster Chapel Student Ministries website. I understand that the photos to be used for these purposes will be chosen tastefully and without intent to hurt or embarrass my child.

PARENT OR LEGAL GUARDIAN'S SIGNATURE

DATE