United Metropolitan Missionary Baptist Church
Youth Ministry
450 Metropolitan Dr. Winston-Salem, NC 27101

STUDENT FORM

MEDICAL INFORMATION AND CONSENT FORM
(Please **Print** with **Blue** or **Black** Ink)

STUDENT INFORMATION

STUDENT
NAME____DOB__________
LAST FIRST MIDDLE MM/DD/YEAR

ADDRESS____

CITY______________________________STATE_____________ZIP________

HOMEPHONE__________________________CELLPHONE_________________

PARENT/GUARDIAN INFORMATION

NAME_____________________________RELATIONSHIP__________________

HOMEPHONE_____________WORKPHONE___________CELLPHONE_______

PLACE OF EMPLOYMENT____

NAME__________________________________RELATIONSHIP_____________

HOMEPHONE____________WORKPHONE___________CELLPHONE_________

PLACE OF EMPLOYMENT____

ALTERNATE IN CASE OF EMERGENCY

NAME__________________________________RELATIONSHIP____________

HOMEPHONE___________WORKPHONE______________CELLPHONE_______

PLACE OF EMPLOYMENT____

TO BE COMPLETED BY A PARENT OR GUARDIAN
(Please sign where signature is required)

MEDICAL INFORMATION

DOCTOR____PHONE____________

Please list all medications your child takes. Include regular medications as well as medication carried in the event of an emergency. (EpiPen, Inhalers)

____

____

Please list any and all allergies your child has (include food, medicine, insects)

____

____

Please list any medical conditions or recent surgical procedures that your child may have that would be pertinent to the health and welfare of your child. (illness, Surgery, Hospital stay)

____

____

Date of last Tetanus Shot_____________________

Please initial beside each medication your child is allowed to have

_______Benadryl ______Dramamine _____Imodium

______Advil (Ibuprofen) ______Aspirin _____Tylenol (Acetaminophen)

_______Pepto-Bismol ______Tums _____Sudaphedrine

_______ALL _______NONE

Any OVER THE COUNTER medications not listed

____

I hereby give permission to administer minor medical treatment to my child,_____________________ Including giving over-the-counter medications. I also authorize release of medical information to the proper insurance company for payment purposes. I understand that it is my responsibility to insure charges incurred for treatment are paid. I release the ministerial staff/or Volunteer First Aid from any liability regarding any adverse drug reaction if the medication is administered as instructed by physician or label in the case of OTC medications.

*SIGNATURE OF PARENT/GUARDIAN*___________________________*DATE*____________

In the event I cannot be reached in an emergency, I hereby give my permission for United Metropolitan Missionary Baptist Church Staff and/or Volunteer Medical First-Aid to dispense the listed prescribed medications, which I have properly provided in it's original prescribed container and/or secure proper medical treatment for my child as named above. Hospital medical staff is authorized to make examinations and to render any medical and/or surgical treatment deemed necessary for my child's health and welfare. I also authorize release of medical information to the proper insurance company for payment purposes. I understand that it is my responsibility to insure charges incurred for treatment are paid. I release the church staff and/or Volunteer First-Aid form any liability regarding any adverse drug reaction if the medication is administered as instructed by physician or label in the case of OTC medications. Also, I relieve the church, the church leadership, the youth coordinators, and chaperones of liability for any accident that may occur on these trips.

*SIGNATURE OF PARENT/GUARDIAN*__________________________DATE_________

FINANCIAL CONSIDERATIONS

For and in consideration of emergency services and goods rendered by or through the attending physician (s), the undersigned hereby guarantees payment in full, immediately upon receipt of the final billing.

SIGNATURE OF PARENT/GUARDIAN_____________________DATE______________

INSURANCE INFORMATION (Please attach a copy of both sides of your insurance card)

INSURANCE COMPANY NAME_______________________POLICY#_____________

NAME OF ADULT CARRIER____

SIGNATURE____DATE_______

PRIVACY NOTICE TO PARENTS

In order to properly care for your child, selected medical information will be available to the youth coordinator. This form will be placed in a binder and secured by Volunteer Medical First-Aid person. All information will be kept confidential and will be divulged only on a need-to-know basis. ***I have read and understand the Privacy Notice:***

SIGNATURE OF PARENT/GUARDIAN__________________________DATE_________