

**Effective dates:** January 1, 2022 to December 31, 2021

**Please print in ink**

Name: \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_\_  
LAST FIRST MIDDLE

Year in school \_\_\_\_\_  Male  Female Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_

Medical insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Mother's name \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Father's name \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

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:

For your child's safety and our knowledge, is your student a—  
 good swimmer     fair swimmer     non-swimmer

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     diabetes  
 frequently upset stomach     physical handicap

Date of last tetanus shot: \_\_\_\_\_

Does your child wear  glasses     contact lenses

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:

# Medical Release & Permission Form

Please list any allergies to drugs, foods, plants, insects, etc:

Please list any prescription medication to be taken by the participant (including what it is taken for, when it is to be taken, dosage information, and any special procedures):

Please list any non-prescription (over-the-counter) medication you do NOT want dispensed to your child:

Please list any additional information relevant to participating in Youth Group activities (dietary needs; surgeries or serious injuries; chronic or recurring illness; medical conditions such as epilepsy or diabetes; psychiatric counseling or indications, etc.):

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases First Lutheran Church (hereinafter the "Church") 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 attend events being organized by the Church. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents, and 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 the Church, 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: \_\_\_\_\_

**Please attach a copy the front and back of insurance card**