Medical Release Agreement

I hereby give permission to the Church Youth Staff and Counselors of Faith Covenant Church to provide routine, non-surgical medical care for my student/child named in this form. This applies to any Church-sponsored activity attended on or off the premises of Faith Covenant Church. In the event said student/child is unconscious or otherwise incapacitated in an emergency situation, I hereby give permission to the nurse or physician selected by the Youth Staff or Counselors to hospitalize, secure proper treatment for and to order injection, anesthesia, or surgery for him or her as named in this form, subject to any exceptions noted below:

Exceptions:

I have read and understand the foregoing Health History and Medical Release Agreement terms and provisions and knowingly execute the same.

_____

Signed Date:
Parent/Guardian/Authorized Custodian
(Please circle appropriate designation)

Acknowledgment of Student/Child:

I am aware that the foregoing Health History and Medical Release Agreement has been signed in my behalf as indicated.

_____

(Signature of Student/Child) Date:

Faith covenant church
Connect ▪ Grow ▪ Serve

Faith Student Ministries

Faith Covenant Church
35415 W. 14 Mile Road
Farmington Hills, MI 48331
248.661.9191
www.4fcc.org

Faith Student Ministries

Health Information/ Medical Release Agreement

_____

Student's name

_____

Parent/Guardian's name

_____

Address

_____

City State

_____

Zip

_____

Home Phone

_____

Father's Cell Phone

_____

Mother's Cell Phone

HEALTH HISTORY

Do you have any chronic or recurring illness? (list)

Do you have any allergies? (list)

Are you taking any medication on a regular basis? (list and give directions)

Are there any specific activities that should be restricted?

Date of the most recent Tetanus booster _____

Please let us know when you come on a trip with the Youth Ministries Program, if you have been exposed to any communicable diseases during the three weeks prior to the trip.

History (check or give appropriate dates where applicable)

Ear Infections _____
Rheumatic Fever _____
Convulsions _____
Diabetes _____
Behavior _____
Hay Fever _____

Ivy Poisoning, etc. _____
Insect Stings _____
Penicillin reaction _____
Other drug reactions _____
_____
Chicken Pox _____

Measles _____
German Measles _____
Mumps _____
Asthma _____

EMERGENCY CONTACT NUMBERS

_____
Contact Person #1

_____
Relationship to student/child

_____
Home Phone #

_____
Cell # (if any)

_____
Fax # (if any)

_____
Contact Person #2

_____
Relationship to student/child

_____
Home Phone #

_____
Cell # (if any)

_____
Fax # (if any)

INSURANCE INFORMATION

_____
Medical/Hospital Insurance Center

_____
Claims Address

_____

_____
Policy or Group #

_____
Insured's (or policy holder's) name

_____
Insured's # (usually policy holder's SS#)

_____
Claims Phone #

PHYSICIAN/DENTIST INFORMATION

_____
Family Physician

_____
Physician's phone #

_____
Dentist

_____
Dentist's phone #

_____
Specialist (please specify)

_____
Specialist's phone #