First Presbyterian Church of Hammond
Youth Ministry Medical Release

General Information:

Name: _____ Date of Birth: _____ HS Graduation Year: _____

Address: _____ City: _____ Zip Code: _____

☐ Please check box if you allow us to use any photos we take of your child on our website and social media platforms.

Mother's Name: _____ Cell Phone: _____ Email: _____

Father's Name: _____ Cell Phone: _____ Email: _____

Emergency Contact (if parent is unavailable)

Name: _____ Phone: _____ Relationship: _____

Family Doctor: _____ Office Number: _____

Family Dentist: _____ Office Number: _____

Family's Medical Insurance Company: _____

Employer's group medical insurance account number: _____

Confidential Heath History

Has he or she had (please mark yes or no to each):		Yes		No	
Allergies		☐		☐	
Heart Ailments		☐		☐	
Diabetes		☐		☐	
Seizures/fainting spells		☐		☐	
Asthma		☐		☐	
Any significant injury or operation		☐		☐	
Taking any medication		☐		☐	
Allergic to Penicillin or other medication		☐		☐	
Any other known ailment we should know about?	(Explain below)	☐		☐	

**Please explain fully if you answered yes to any of the above questions and/or any additional information that would be helpful for leaders to know when ministering to your child.

Date of last Tetanus shot: _____

Permission for medical treatment:

In the event my son or daughter becomes ill or sustains injury while in the care of or in the supervision of the First Presbyterian Church of Hammond youth workers, they are given permission to administer first aid for my son or daughter's relief. Consent is also given to admit him or her to any hospital facility and for all medical, surgical, diagnostic, and hospital procedures or treatment as may be performed or prescribed, including the administration of such drugs or medications, by a physician for him or her when such treatment is deemed immediately necessary or advisable to safeguard my son or daughter and it is not advisable or practical to return him or her to me or receive my instruction for his or her care. I waive my right to informed consent for said treatment.

Name of Parent/Guardian: _____

Signature: _____ Date: _____