

UCCH Youth Medical and Liability Release Form

(Please Print in Ink)

Date _____

Youth Name _____ Age _____ Birthdate _____
 Grade in School _____ Male ___ Female ___ Youth E-mail _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Youth Cell Phone _____ Other _____

Medical Insurance Company _____ Tel. # of Insur. Co. _____

Policy Holder _____ Policy # _____ Group # _____

Parent/Guardian Name _____ Ph. H _____ W _____ C _____

Parent/Guardian Name _____ Ph. H _____ W _____ C _____

Parent/Guardian Name _____ Ph. H _____ W _____ C _____

Parent/Guardian Name _____ Ph. H _____ W _____ C _____

Emergency Contact _____ Ph. H _____ W _____ C _____

Physician: _____ Office Phone: _____

Dentist: _____ Office Phone: _____

MEDICAL HISTORY: The following information must be completed by the parent/guardian. Please describe any physical or psychological conditions and any actions required. Please keep a copy of the completed form for your records. If there are any changes to this medical history or insurance, please update the church records immediately.

General Questions (please explain "yes" answers in the space provided beside the question, in the space below, or if necessary, add another page with details).

Has / does the participants..... (please circle the correct answer)

- | | | | |
|---|-----|----|-------|
| 1. Had any recent injury, illness, or infectious disease? | Yes | No | _____ |
| 2. Have a chronic or recurring illness/condition? | Yes | No | _____ |
| 3. Ever been hospitalized? | Yes | No | _____ |
| 4. Ever had surgery? | Yes | No | _____ |
| 5. Have frequent headaches? | Yes | No | _____ |
| 6. Ever had a head injury? | Yes | No | _____ |
| 7. Ever been knocked unconscious? | Yes | No | _____ |
| 8. Wear glasses, contacts, or protective eyewear? | Yes | No | _____ |
| 9. Ever had frequent ear infection? | Yes | No | _____ |
| 10. Ever passed out during or after exercise? | Yes | No | _____ |
| 11. Ever been dizzy during or after exercise? | Yes | No | _____ |
| 12. Ever had seizures? | Yes | No | _____ |
| 13. Ever had chest pain during or after exercise? | Yes | No | _____ |
| 14. Ever had high blood pressure? | Yes | No | _____ |

- | | | | |
|--|-----|----|-------|
| 15. Ever been diagnosed with a heart murmur? | Yes | No | _____ |
| 16. Ever had back problems? | Yes | No | _____ |
| 17. Ever had problems with joints (e.g. knees, ankles)? | Yes | No | _____ |
| 18. Have any skin problems (e.g. itching, rash, acne)? | Yes | No | _____ |
| 19. Have diabetes? | Yes | No | _____ |
| 20. Have asthma? | Yes | No | _____ |
| 21. Had mononucleosis in the past 12 months | Yes | No | _____ |
| 22. Had problems with diarrhea/constipation? | Yes | No | _____ |
| 23. Had problems with sleepwalking? | Yes | No | _____ |
| 24. If female, have abnormal menstrual history? | Yes | No | _____ |
| 25. Have a history of enuresis (bed-wetting)? | Yes | No | _____ |
| 26. Ever had an eating disorder? | Yes | No | _____ |
| 27. Ever had emotional difficulties for which professional
Help was sought? | Yes | No | _____ |
| 28. Have any known allergies? | Yes | No | _____ |
| 29. Ever tried to harm themselves? | Yes | No | _____ |

Other or additional comments:

1. For your child's safety and our knowledge, is your youth a: ___good swimmer ___fair swimmer ___non-swimmer

2. Does your child have allergies to?
 ___medications ___hay fever ___foods ___insect bites ___poison ivy

Please describe:

3. Does your child suffer from, or has he/she ever experienced, or is he/she being treated currently for:
 ___asthma ___epilepsy/seizure disorder ___heart trouble ___diabetes
 ___frequent upset stomach ___physical challenges other: _____

Please describe:

4. Date of last tetanus shot: _____

5. Please list and explain any major illnesses or hospitalizations the child has experienced during the last year:

6. Please list and explain any minor illnesses or hospitalizations the child has experienced during the last year:

7. Is the child currently under the care of a physician for any condition?
 If so, what is the condition?

...and what is the treatment?

8. Anything else the church staff and chaperones should know?

Restrictions – Please indicate any restrictions or limitations your child has for certain activities.

Medications (please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Send enough medication for the duration of the trip and send it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, the frequency of administration. Please indicate if your child needs to be **discretely** reminded to take their medication. _____

Are there any medications that need to be administered for your child?

- | | | | |
|-----------------------------|---------------------------|--------------|-----------------|
| 1) Name of Medication _____ | For What Condition? _____ | Dosage _____ | Frequency _____ |
| 2) Name of Medication _____ | For What Condition? _____ | Dosage _____ | Frequency _____ |
| 3) Name of Medication _____ | For What Condition? _____ | Dosage _____ | Frequency _____ |
| 4) Name of Medication _____ | For What Condition? _____ | Dosage _____ | Frequency _____ |

Parent/Guardian Signature

This form (1) gives your permission for your child to ride in church transportation and (2) gives the group leaders' authorization to secure medical aid for your child should it be necessary.

To the best of my knowledge, this health history is correct and complete.

I, _____ consent to allow --- _____

(Parent or Guardian Signature)

(Youth's name – please print)

to be transported from and to United Church of Chapel Hill in church transportation for various youth activities. I hereby authorize any hospital, clinic, physician, doctor, nurse, or technician to furnish my _____ (relation to minor), named above, any medical care and treatment necessary as a result of injuries sustained and other emergency medical care treatment as the circumstances require while being transported from and back to the church while at the place of destination. I hereby authorize a representative of United Church of Chapel Hill to retain or acquire said medical care and treatment in my behalf if I cannot be reached by telephone or there is not time or opportunity to make such a telephone call. I agree not to hold such a person responsible for any damages arising from the giving of such consent.

This is the _____ day of _____ (month), in the year _____.

Updates:	Date _____	Initials _____	Date _____	Initials _____
	Date _____	Initials _____	Date _____	Initials _____