

[Parents, please fill out and return to person in charge of activity  
or to the church office.]

**Cary Christian Church  
Children's and Youth Ministry Medical Release**

**Student's Name** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**Medical Information**

Youth's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Primary Insured \_\_\_\_\_

**Health History** (please check all that apply)

Frequent colds     Seizure disorders     Physical disability     Sleep disturbances

Stomach upsets     Diabetes     Learning disability     Motion sickness

Asthma     Vision/Hearing impairment     Emotional/Behavioral disability     Appliances (contact lenses, retainers, etc.)

Other \_\_\_\_\_

Allergies \_\_\_\_\_

If any of the above are checked, please provide important details (attach separate page if needed):

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

Is your son/daughter taking a prescription or non-prescription medication? **Yes No**

If yes, please provide the following:

Medication \_\_\_\_\_ Dosage & time(s) administered \_\_\_\_\_

Medication \_\_\_\_\_ Dosage & time(s) administered \_\_\_\_\_

If there are more medications, please list them on a separate sheet of paper and attach it to this form.

**Can your son/daughter independently take the proper dosage of medication at the right times?**

Yes     No

If the answer is no, please contact the adult in charge to make appropriate arrangements.

I give my child permission to administer his/her own medication X\_\_\_\_\_

**STATEMENT OF CONSENT**

I do hereby consent to an x-ray exam, anesthetic, medical diagnosis or treatment and hospital services that may be rendered to said minor, under the general or specific instruction of

\_\_\_\_\_ (youth's physician) or, if unavailable, the attending physician at a hospital or clinic. I understand that in an emergency, whenever possible, an attempt will be made to communicate with me prior to use of this permission and understand that this consent is in advance of any specific diagnosis or treatment, and is given to encourage those persons who have temporary custody of my child, in my absence, and said physician to exercise their best judgment as to the requirements of such diagnosis or said medical treatment. I understand that any and all medical expenses incurred are my responsibility, and that there is no medical coverage provided by Cary Christian Church.

**Signature of parent/guardian** \_\_\_\_\_ **Date** \_\_\_\_\_