



FLORIDA HOSPITAL CHURCH

FHC YOUTH MEDICAL RELEASE FORM

Student's Last name First name Birthday (month/day/year)

Address

City State Zip Code

Home phone number Cell phone number

PARENT/GUARDIAN INFORMATION

Parent/Guardian's Name Phone number

Contact this person in case of emergency (must be 18 years of age or older)

Name Phone number

MEDICAL INFORMATION

Name of Minor Date of Birth (Month/Day/Year)

Address City State Zip

Name of Parent or Guardian:

Home Phone () Work Phone ()

If unable to contact parent or guardian, please call:

Name Relation: Phone ()

Insurance Co.: Policy No. Group No.

Name of Physician:

The above named minor has my permission to attend and participate in Florida Hospital Church Youth outings/events. In the event of an emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the supervising members to act on my behalf in administering emergency medical treatment including hospitalization, anesthesia, surgery, or injections of medication for accident or illness as necessary to, during and from an outing/event.

I hereby voluntarily waive any claim against the leaders and sponsoring institution for any and all causes which may arise in connection with this activity. I also certify, that to the best of my knowledge, the minor named above is physically fit to engage in the activities of Florida Hospital Church. In the event any of the medical or insurance information changes, it is my responsibility to update the form.

Signature of parent or guardian Date

Check all items that apply, past or present, to your health history. Explain any "Yes" answers.

Allergies:

Food

Yes _____ No _____

Medicines

Yes _____ No _____

Insects, plants

Yes _____ No _____

Animals

Yes _____ No _____

Explain: _____

General Information - have or subject to:

Asthma

Yes _____ No _____

Cancer / leukemia

Yes _____ No _____

Convulsions/seizures

Yes _____ No _____

Diabetes

Yes _____ No _____

Heart trouble

Yes _____ No _____

Hemophilia

Yes _____ No _____

High blood pressure

Yes _____ No _____

Kidney disease

Yes _____ No _____

Any condition that may require special care, medication, or diet

Yes _____ No _____

Explain: _____

List any medications to be taken:

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games:

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc: _____

Have difficulty with:

Eyes, ears, nose, throat

Yes _____ No _____

Digestion

Yes _____ No _____

Bed-wetting

Yes _____ No _____

Lungs

Yes _____ No _____

Sleepwalking

Yes _____ No _____

Explain:

Immunizations up to date:

Tetanus toxoid

Yes _____ No _____

Measles

Yes _____ No _____

Polio

Yes _____ No _____

Diphtheria

Yes _____ No _____

Mumps

Yes _____ No _____

Pertussis

Yes _____ No _____

Rubella

Yes _____ No _____

Explain:
