CONFIDENTIAL

2016-2017 FUMC Youth MEDICAL INFORMATION

Youth's Full Name:	______	Date of Birth:	______
Address:	______	Male ______	Female ______
City / Zip:	______	Age	______
Home Phone:	______	Youth Cell Phone:	______
Name of School:	______	Grade:	______
Father's Name:	______	Home Phone:	______
Occupation:	______	Work Phone:	______
Email:	______	Cell Phone:	______
Mother's Name:	______	Home Phone:	______
Occupation:	______	Work Phone:	______
Email:	______	Cell Phone:	______

Person to contact if parent(s) is unavailable: ______

Relationship:	______	Home Phone:	______
Occupation:	______	Work Phone:	______
		Cell Phone:	______
Physician Name:	______	Physician Phone:	______

<u>HEALTH HISTORY</u> (check all those that apply)

ILLNESSES:		DISEASES:		ALLERGIES:		SUBJECT TO:	
Frequent ear infections	______	Chicken pox	______	Penicillin	______	Sleep Walking	______
Frequent Colds / Sore Throats	______	Measles	______	Aspirin	______	Fainting	______
Sinusitis / Bronchitis	______	Mumps	______	Other	______	Bedwetting	______
Strep Throat	______	German Measles	______	Food	______	Constipation	______
Mononucleosis	______	Whooping Cough	______	Insect Stings	______	Other	______
Heart Defect / Disease	______	Tuberculosis	______				
Epilepsy / Convulsions	______	Polio	______	Poison Ivy / Oak / Sumac	______		
Bleeding / Clotting Disorders	______	Diabetes	______	Hay Fever, etc.	______		
Hypertension	______	Asthma	______				
Stomach Problems	______	Arthritis	______				

Other Diseases or Details of Above:

______

Are immunizations up to date? ______ Date of last Tetanus Shot ______

If no, please explain Date of last TB skin test ______

______

Any activity limitations?

______

Do you wear contacts? ______

Any specific activities to be encouraged?

______

Any specific activities to be restricted?

______

List any medications or drugs taken regularly.

______

Any special medical or dietary regime to be continued?

______

Suggestions for Chaperones or Church Leaders

______

MEDICAL RELEASE
Valid June 1, 2016 to August 31, 2017

Name of Youth: ____
Insurance issued in the name of: ____
Is coverage for dependents? ______________
Medical/Health Insurance Co. Name: _______________________________________
Policy Number: _____________________ Group Number: _____________________
Preauthorization Phone # _____________________________

I certify that the above-named youth is my child or my legal ward and resides with me as his or her legal guardian. In the event he/she becomes ill, is injured, or for any reason requires medical care or attention while attending a First United Methodist Church function or activity, I do hereby consent to any and all medical or surgical treatment, including anesthesia and operations ("Medical Treatment"), which may be deemed advisable or necessary by any qualified physician selected by agents or officials ("Staff") of the First United Methodist Church to further the health, healing, reparation, and/or physical and mental welfare of the above named youth. In the event treatment is required which a physician or other health care provider refuses to administer without my/our consent, I/we hereby authorize the Staff at First United Methodist Church or any other representatives of First United Methodist Church ("Staff"), to give such consent and I further agree to hold any person harmless from any claims, demands, or suits of any nature arising from providing such consent, so long as the Medical Treatment is authorized only for care by or under the supervision of a licensed physician. I further authorize the release of the listed medical information to appropriate medical personnel and/or the health coverage insurance companies. I will notify the Staff if I believe or have knowledge that there are any health considerations that would prevent my child's participation in any activity. I also give my permission for Staff to restrict my child from participation in any activities for which concerns arise regarding health or other reasons.

The intention of this release is to grant authority to the Staff to consent to the administration and performance of any and all examinations, treatments, anesthetics, operations, diagnostic procedures, and/or other Medical Treatment which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. I accept responsibility as guarantor for payment of all medical expenses incurred for medical treatment for the above named youth, even though the parties to this Release may believe that some or all of the expenses may be the responsibility of one or more insurance companies. This payment will be made by me or by my insurance company providing coverage for the above-named youth.

As the parent (or legal guardian), I the undersigned, certify that my child, named above, has my express permission to participate in all activities, of any nature, sponsored by First United Methodist Church for the 2016-2017 school calendar year. I fully release First United Methodist Church, its authorized representatives and staff from any and all liability of any kind and character upon any claim, demand, or cause of action that might be asserted in our behalf, or on behalf of the above named child, against said church, representatives or staff.

Signature of Youth: I _________________________________ understand and agree to abide with the restrictions placed on my activities by my parent/guardian.

Signature of Parent/Guardian:_____________________________ Date __________

Sworn to and subscribed before this __________ day of _______________________ .

____
NOTARY PUBLIC
State of Alabama, My commission expires:
_____________________________________ ___
PRINT, TYPE OR STAMP COMMISSIONED NAME OF NOTARY PUBLIC