Annual Medical Release Form

August 2019 - August 2020

Life Community Church
10020 Foothills Blvd.
Roseville, CA 95747

GENERAL INFORMATION

Student Name_____ **Date of Birth**_____ **Male**_____ **Female**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Student Email Address_____ **Adult Shirt Size**_____

Grade in School _____ **School**_____ **Student Cell Phone**_____

Parent(s) or Guardian(s) Name(s)_____ **Home Phone ( )**_____

Father's Work Phone ( )_____ **Mother's Work Phone ( )**_____

Father's Cell Phone ( )_____ **Mother's Cell Phone ( )**_____

Health/Accident Insurance Company_____ **Policy No**_____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE, ENTER "NONE" ABOVE.

In case of emergency, notify:

Name_____ **Relationship**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone ( )_____ **Work Phone ( )**_____ **Cell Phone ( )**_____

Alternate contact name_____ **Alternate's phone ( )**_____

ALLERGIES

Please list all known (food or other) allergies._____

_____

_____

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the release form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication_____
Strength_____ Frequency_____
Approximate date started_____
Reason for medication_____

Medication_____
Strength_____ Frequency_____
Approximate date started_____
Reason for medication_____

☐ **No medications** ☐ **Additional medications (sheet attached)**

Administration of the above medication(s) is approved by:_____
Parent/Guardian Signature

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medications unless instructed to do so by your doctor.

Allergies:_____

Grade:_____

Full name:_____

PERMISSION FOR OVER THE COUNTER MEDICATIONS

The purpose of this form is to document permission for leaders and/or adult volunteers of Elevate Student Ministries to administer certain over the counter medications that were not covered on the first page of this form. This page does not change what was already signed regarding prescribed medication, but instead, supplements it.

I, _____ (printed first and last name of parent/guardian) give permission to the Leaders and/or Adult Volunteers of Elevate Student Ministries to administer the following over the counter medications to my son/daughter _____ (print minor's name) during the attended youth event. Elevate Student Ministries Leaders and/or Adult Volunteers agrees the use of the medication is reasonable for my son/daughter under the circumstances, and to be administered as determined by the weight and age of my son/daughter and the relative recommended prescribed dosage on the medication.

1.	**The correct dosage of Tylenol or equivalent (acetaminophen)**	**□ Yes**	**□ No**
2.	**The correct dosage of Advil or equivalent (ibuprofen)**	**□ Yes**	**□ No**
3.	**The correct dosage of Sudafed or equivalent (pseudo ephedrine HCL)**	**□ Yes**	**□ No**
4.	**The correct dosage of Benadryl or equivalent (diphenhydramine)**	**□ Yes**	**□ No**
5.	**The correct dosage of Claritin**	**□ Yes**	**□ No**
6.	**The correct dosage of Mucinex**	**□ Yes**	**□ No**
7.	**The correct dosage of Pepcid, Zantac or Tagmet (famotidine, ranitidine or cimetidine)**	**□ Yes**	**□ No**
8.	**The correct dosage of Tums**	**□ Yes**	**□ No**
9.	**The correct dosage of Triple-Antibiotic Ointment**	**□ Yes**	**□ No**
10.	**The correct dosage of Corticosporin ointment/cream**	**□ Yes**	**□ No**
11.	**The correct dosage of Imodium**	**□ Yes**	**□ No**
12.	**The correct dosage of Delsym (Dextromorphan)**	**□ Yes**	**□ No**
13.	**The correct dosage of Pepto-Bismol for those over 15 years of age.**	**□ Yes**	**□ No**

I acknowledge that by signing this document, I am agreeing to release Life Community Church, including its members, trustees, employees and agents (herein referred to as releasees) from all liability. I have therefore been advised to read this document carefully before signing it. The undersigned agrees to inform Life Community Church of any changes to the medical records or medical insurance of the student whose name is printed above. The undersigned parent or legal guardian for himself or herself and personal representatives, assigns, heirs and next of kin (herein referred to as releasers), hereby releases, holds harmless, waives, discharges and covenants not to sue or bring any action whatsoever against the above releasees from all liability to the releasers for all loss or damage and any claim or demands on account of injury to the person or property or resulting death of the releasers, whether caused by negligence of releasees or otherwise while participating in activities associated with the activity named above. The undersigned is fully aware of the inherent hazards and risks and hereby elects to participate voluntarily and assume all risks of loss, damage or injury that may be sustained by him or her. This release shall include (without limitation) any claims or negligence or breach of warranty that the releasers may have against the releasees, including reasonable attorneys' fees and costs, except to the extent that a claim might be based upon the sole and exclusive gross negligence of the releases. In the event of an emergency, staff will attempt to contact parent/guardian immediately. I hereby give permission to the physician or dentist selected by the staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, and/or surgery for the student named herein. This completed form may be copied for transportation record.

Parent or Guardian's Signature_____ **Date**_____

Parent or Guardian's Signature_____ **Date**_____

This Annual Medical Release Form is valid for 12 months.