

Flood Youth Medical Release Forms

Member Information

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ ZIP Code: _____
Birth date: _____ Age: _____
Grade: _____ Home Phone: _____

Guardian Information

Parent/Guardian: _____ Relationship: _____
Address: _____
City: _____ State: _____ ZIP Code: _____
Work Phone: _____ Home Phone: _____

Medical Information

Emergency Contact: _____
Relationship: _____ Emergency Phone: _____
Doctor's Name: _____
Doctor's Phone: _____
Hospital Preference: _____
Insured With: _____ Insurance #: _____
Prescriptions: _____

Date of Last Tetanus Shot: _____

Allergies and other conditions:

_____ Insect bites _____ Food Allergies _____ Chronic Asthma _____ Physical Handicaps
_____ Hay Fever _____ Heart Condition _____ Diabetes _____ Epilepsy
_____ Other

If you checked any of the above, please give details (i.e. normal treatment for allergic reactions, etc.): _____

Any activity restrictions: _____ YES _____ NO If yes, please explain:

Please Initial:

_____ If you have medical insurance you will be billed for medical charges in the case of illness or injury while your son/daughter is on a church related activity.

_____ I give my permission to New Horizon Christian Center staff to obtain the emergency medical treatment they deem necessary for my child's well being.

Parent/Guardian Signature

Date

Comments:

