CALVARY CHAPEL SANTA FE SPRINGS

WORD · PRAYER · WORSHIP · MISSIONS

MEDICAL HISTORY AND RELEASE FORM

EVENT NAME: _____

EVENT DATE: _____

GENERAL CHILD/YOUTH INFORMATION

Child's Name: _____ Age: _____ Gender: _____

Parent/Guardian Name: _____

Home Phone: _____ Work: _____

Cell Phone: _____

Home Address: _____

City: _____ CA Zip: _____

In Emergency, notify: _____

Phone: _____

Address: _____

City: _____ CA Zip: _____

Relationship:_____

HEALTH HISTORY (Please list dates as well)

Frequent Colds _____ Kidney Trouble _____ Chickenpox _____
Sinusitis_____ Bedwetting_____ Measles_____
Mumps_____ Coughs_____ German Measles_____
Convulsions_____ Abscessed Ears_____ Athlete's Foot_____
Bronchitis_____ Sleepwalking_____ Whooping cough_____
Fainting_____ Constipation_____ Nose Bleeds_____
Stomach Upsets_____ Rheumatic Fever_____ Tuberculosis_____
Serious Ivy Oak or Sumac_____ Poisoning_____ Asthma_____

Please continue on flip side

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Please continue on flip side

HEALTH HISTORY (CONTINUED)

Operation or Serious Injuries_____

Please Explain:

_____

Allergic Reactions:

Bee Sting_____ Penicillin_____ Other Drugs_____

List all medications currently being taken: (include dosage):

_____

_____

List activities that are to be restricted, such as swimming, climbing, etc:

_____

_____

MEDICAL AND LIABILITY RELEASE FORM

Should emergency medical treatment be necessary, I authorize Leadership or Overseers of **Calvary Chapel Santa Fe Springs** to act on my behalf and approve appropriate treatment. I also release from any and all liability of **Calvary Chapel Santa Fe Springs** and its board as well as any of the church staff, board, and adult sponsors, in the event of any accident in route, during, and returning from this event.

I hearby give permission to the nurses or physician selected by the **Calvary Chapel Santa Fe Springs** leadership or overseers to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child named above as deemed necessary to avoid extreme or permanent physical damage or death.

Health Insurance Carrier

_____

Policy Number: _____

Name of Insured: _____

Copy of Medical Card attached: _____ YES

_____ _____

Parent/Guardian Signature Date

HEALTH HISTORY (CONTINUED)

Operation or Serious Injuries_____

Please Explain:

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