MEDICAL RELEASE FORM

First Congregational Church of Santa Barbara, UCC

Full Name: _____ Date of Birth: ____/____/_____
First Middle Last

Address: _____
Street City State Zip

Email: _____ Cell Phone: _____ Home Phone: _____

Emergency Contacts

Primary Emergency Contact: _____ Relationship:_____

Cell number: _____ Home/other contact number(s): _____

Other Emergency Contact: _____ Relationship:_____

Cell number: _____ Home/other contact number(s): _____

Medical Information

Health Insurance Company: _____ Policy #: _____

Group #: _____ Name of Policy Holder: _____

Doctor's Name: _____ Phone:_____

Current medications: List name, dosage, frequency (if needed use back side of this sheet)

_____ _____

_____ _____

For Parents/Legal Guardian: [ ]Youth may self-administer above medications.
[ ]Group Coordinator or designated chaperone may assist as needed.

Permission **is** [ ] *or* **is not** [ ] granted [**check one**] for this youth to receive over-the-counter medications from trip coordinator as needed. **Parent/Legal Guardian initials**: _____

Health History: List all conditions, including but not limited to allergies, sleepwalking, convulsions, diabetes, mononucleosis, epilepsy, mobility issues, emotional problems or hyperactivity, fatigue, headaches, dizziness. Please indicate how long since last occurrence of problem. Use additional paper if necessary.

_____

_____

_____

By signing this form I verify that the health/medical and insurance information provided on this form is true, accurate and complete. In case of medical emergency, I give permission to the physician(s) selected by my/my youth's group coordinator to secure proper medical treatment for the participant named on this form. I agree to pay additional costs that arise from such medical treatment if not covered by insurance.

_____ _____
Signature of Parent/Legal Guardian (for youth) or Adult Participant Date