

**Fairview United Methodist Church – Youth Ministries  
Health Form / Permission / Liability Release**

Student Name: \_\_\_\_\_ Grade (7-12 ): \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Gender (M/F): \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Address \_\_\_\_\_ E-Mail: \_\_\_\_\_

Primary Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

(if applicable)

Secondary Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Insurance Subscriber's Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Insurance Claims Address: \_\_\_\_\_  
 Pre-Authorization Phone Number, if required: \_\_\_\_\_

Physician \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Dentist: \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Orthodontist: \_\_\_\_\_ Phone No. \_\_\_\_\_

**Has youth ever had the following? If so, write in the date.**

Ear Infection \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Measles \_\_\_\_\_ Diabetes \_\_\_\_\_  
 Frequent Headaches \_\_\_\_\_ Mumps \_\_\_\_\_ Convulsions \_\_\_\_\_ Bleeding Disorders \_\_\_\_\_  
 ADD/ADHD \_\_\_\_\_ Fainting \_\_\_\_\_ Cancer \_\_\_\_\_ Mouth Braces \_\_\_\_\_  
 Serious Injuries \_\_\_\_\_ Immune Disorders \_\_\_\_\_ Heart Defect/Disease \_\_\_\_\_  
 Operations \_\_\_\_\_ Breathing Difficulties (Asthma, COPD) \_\_\_\_\_  
 Other: \_\_\_\_\_

**Has youth ever had an allergic reaction to: (describe)**

Hay Fever \_\_\_\_\_ Ivy Poisoning \_\_\_\_\_ Insect Sting \_\_\_\_\_ Penicillin \_\_\_\_\_  
 Other Medications (please list): \_\_\_\_\_

Foods: \_\_\_\_\_

Does youth require an EPI Pen \_\_\_\_\_ or inhaler \_\_\_\_\_ If so will they be bring this item on the trip? \_\_\_\_\_  
 If yes, do they know how to use it? \_\_\_\_\_

**Does youth have any other special considerations? (emotional or behavioral concerns, special diet, etc.)**

(For Females)

Has youth menstruated? \_\_\_\_\_ If no, has she been told about it? \_\_\_\_\_ Is menstrual history normal? \_\_\_\_\_

**Immunization History-** Give date of most recent immunization or booster:

Tuberculin Test \_\_\_\_\_ Tetanus \_\_\_\_\_ Polio \_\_\_\_\_ Mumps \_\_\_\_\_ Measles \_\_\_\_\_  
Rubella \_\_\_\_\_ DPT \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Meningitis \_\_\_\_\_ Other \_\_\_\_\_

**Over-The-Counter Medication:** By checking below, you give permission for an adult designated by the youth program to administer over the counter medications as needed according to the specific directions on the product label unless otherwise directed by a physician. These may include: Acetaminophen (Tylenol), Ibuprofen, Excedrin, Midol, Maalox, Mylanta, Pepto Bismol, Kaopectate, Imodium, Benadryl, Sore Throat Lozenges, Hydrocortisone Cream, Calamine Lotion, Insect Bite Relief, Insect Repellent Containing DEET, Sunscreen, or other medications as deemed necessary by the designated adult.

- \_\_\_\_\_ My child may receive **ALL** over the counter medications as needed
- \_\_\_\_\_ My child may receive all **EXCEPT** the following: \_\_\_\_\_
- \_\_\_\_\_ My child may receive **ONLY** the following: \_\_\_\_\_
- \_\_\_\_\_ My child may **NOT** receive any over the counter medications

Will your youth be bringing medication? \_\_\_\_\_. Will they be administering their own medication? \_\_\_\_\_. Does the staff need to administer the medications? \_\_\_\_\_

**Prescription and Routine Medications-** Please list all medications to be taken regularly. List exact dosage and dispensing orders prescribed by your doctor. Medication must be in original containers.

Medication	Dosage	Times Taken (Breakfast, Lunch, Supper, Bedtime, Other)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**The following must be signed under witness of a Notary Public:**

I \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_, a minor under the age of 18, give my consent for the minor named above to participate in all events and activities organized by Fairview United Methodist Church. I also give consent for the pastor, youth director, staff member, or other adult volunteer (over the age of 18) to sign for any reasonable medical attention deemed necessary by a licensed physician for the minor should it become necessary. By signing below, I release the church, its employees, and volunteers of any and all liability for injury, loss, or damage to person or property during the course of his/her involvement in the activities or medical treatment. I also acknowledge that the health insurance information provided above is accurate and I will be fully responsible for any and all costs of medical treatment and/or property damage caused by the student. Further, I agree to bring the minor home at my expense should they become ill or if deemed otherwise necessary by the pastor, youth director, or paid staff member. This consent will remain in effect unless rescinded in writing and acknowledged by the return of this original form to the parent or guardian.

Parent/Guardian Signature \_\_\_\_\_

The above signed appeared before me, a Notary Public of \_\_\_\_\_ County, in the state of \_\_\_\_\_.

Witness my hand and official seal this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public \_\_\_\_\_  
My Commission Expires \_\_\_\_\_