Revised 7/19/2021

Name(Last, First):_____

FAIRVIEW CHURCH
LOVE • GROW • SERVE

Health Form / Permission / Liability Release

Minor's Name:_____ Grade:_____
DOB:_____ Gender (M/F):_____ Home Phone:_____ Cell Phone:_____
Address_____
_____

Primary Parent/Guardian:_____ Home Phone:_____
Address:_____ Work Phone:_____
City:_____ State:_____ Zip:_____ Cell Phone:_____
Email: _____

(if applicable)
Secondary Parent/Guardian:_____ Home Phone:_____
Address:_____ Work Phone:_____
City:_____ State:_____ Zip:_____ Cell Phone:_____
Email: _____

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 minor ever had the following? If so, give 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_____ Breathing Difficulties (Asthma, COPD) _____
Operations_____ Other:_____

Has minor ever had an allergic reaction to: (describe)
Hay Fever_____ Poison Ivy_____ Insect Sting_____ Penicillin_____
Other Medications (please list):_____
Foods:_____
Does minor require an EPI Pen _____or inhaler_____ If so, will they be bringing this item with them?_____.
If yes, do they know how to use it?_____

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

(For Females)
Has student 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 Ministry Staff Leader 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 child be bringing medication?_____. If prescription medications are needed to be brought with them, contact your child's Ministry Staff Leader for further handling details.

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)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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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 Pastors, Ministers, paid staff members, or other adult volunteers (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, Ministers, or paid staff members. 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_____