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CENTRAL CONGREGATIONAL CHURCH, UCC
One Worthen Street P.O. Box 339
Chelmsford, MA 01824
Phone 978-256-5931 Fax 978-250-3565
office.admin@cccchelmsford.org

This form for:
Youth group activities

MEDICAL RELEASE FORM

Name of Youth _____ Birthdate _____

Address _____ Phone _____

Name of parent/guardian _____

Youth's physician _____ _____Phone _____

Emergency contact _____ _____Phone _____

Health history (please check all that apply):

Frequent colds	Seizure disorder	Physical impairment
Appliances (e.g. retainer, contact lenses)	Stomachaches	Diabetes
Sleep disturbances	Mental impairment	Asthma
Emotional disability	Vision/hearing impairment	Motion sickness
Behavioral problems		

Other (describe) _____
Allergies (describe) _____
Does your child carry an Epipen? _____ An inhaler? _____
Give important details of items that are checked: _____
_____

Date of last tetanus shot _____

Is your son/daughter taking a prescription or non-prescription medication? ___Yes ____No
If yes, complete the following:

Medication_____

Dosage and frequency _____

Medication_____

Dosage and frequency _____

Medication_____

Dosage and frequency _____

Can your son/daughter be expected to take the right amount of medication at the proper time? __Yes ___ No

(If the answer is no, then arrangements must be made with the adult in charge.)

___ I give my child permission to administer his/her own medications.

All medications, both prescription and non-prescription, MUST be in the original container and properly labeled. This applies even if your son/daughter has permission to self-administer his/her medications.

_____ _____

Signature of parent/guardian **Date**

Youth's insurance carrier _____

Policy number or ID number _____

Subscriber's name _____

Subscriber Number _____

Insurance company customer service number _____

Other pertinent information _____

_____

Statement of Consent

I, the undersigned, parent/legal guardian of _____ do hereby consent to any X-ray exam, anesthetic, medical diagnosis, or treatment and hospital services that may be rendered to my son/daughter, under the general or specific instructions of the on-call physician at a hospital or clinic. It is understood that this consent is given in advance of any specific diagnosis or treatment, and it is given to encourage those persons who have temporary custody of my child in my absence, and said physician, to exercise their best judgment as to the requirements of such diagnosis or said medical treatment.

I understand that any and all medical expenses incurred are my responsibility and that there is not medical insurance coverage provided by Central Congregational Church of Chelmsford, Massachusetts.

This consent will remain in effect for one year from signing unless otherwise specified.

_____ _____

Signature of parent/guardian **Date**