Approved on 2026 08 12

CENTRAL CONGREGATIONAL CHURCH, UCC
One Worthen Street Chelmsford, MA 01824
Phone 978-256-5931 office.admin@cccchelmsford.org

This form for:
All Participants

MEDICAL RELEASE FORM

Full name: _____

Date of birth: _____ Age: _____ Gender: _____

Address: _____

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____

Primary phone: _____ Secondary phone: _____

Alternate contact: _____Alternate phone: _____

Insurance carrier _____

Policy number or ID number _____

Subscriber's name _____

Subscriber Number _____

Insurance company customer service number _____

Other pertinent information _____

_____

Health history (please check all that apply):

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

Give important details of items that are checked: _____
Attach additional page if necessary

Other(describe) _____

Allergies(describe)_____

Do you use an Epipen? _____ Autoinjector? _____ Exp. date (if yes)

Do you use an Asthma Rescue ? _____ Inhaler? _____ Exp. date (if yes)

Date of last tetanus shot _____

Are there prescription or non-prescription medications taken regularly? ___Yes ____No

All medications, both prescription and non-prescription, MUST be in the original container and properly labeled.

If yes, complete the following:

Medication_____

Dosage and frequency _____

Medication_____

Dosage and frequency _____

Medication_____

Dosage and frequency _____

I have provided accurate information for the Participant:

_____

Signature **Date**

My relationship to the participant is:

☐ **Self** ☐ **Parent / Guardian of Youth/Child**

Complete this section for minor participants only:

If the Participant is a minor can they 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.)

_____ Initial here to give permission for your minor to administer their own medications.

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 minor, 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 minor 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 no medical insurance coverage provided by Central Congregational Church in Chelmsford, Massachusetts, UCC.

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

_____

Signature of parent/guardian **Date**

_____

Printed Name & Contact Information of parent/guardian if different from Emergency Contact