

## Student Medical Information Form

### Personal Information

Name \_\_\_\_\_  
Age \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
Guardian's Name, if applicable \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Parent/Guardian Phone number (day) \_\_\_\_\_ (evening) \_\_\_\_\_  
Parent/Guardian Cell Phone Number \_\_\_\_\_  
Additional Contact Numbers \_\_\_\_\_

### Emergency Contact Information

Contact person (other than parent/guardian) in case of emergency \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone number \_\_\_\_\_

Physician's name \_\_\_\_\_  
Physician's phone number \_\_\_\_\_

### Insurance Information

Name of insurance company \_\_\_\_\_  
Group Number \_\_\_\_\_ Policy Number \_\_\_\_\_  
Policy Holder's Name and Birthdate \_\_\_\_\_  
Phone number of insurance company \_\_\_\_\_  
(Please attach a photocopy of both sides of your insurance card with this form)

### Medical History

Blood Type \_\_\_\_\_

Please list any known allergies and how you react:

\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to bee stings? \_\_\_\_\_ If yes, do you carry Epi-pen? \_\_\_\_\_

List any medications that you are currently taking (generic name, strength, frequency of dosage, reason for taking):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please note that medications for minors must be in the original pharmacy bottle with name of student and dosage.)

Parent signature (if participant is a minor) for permission to administer over the counter drugs like Ibuprofen, acetaminophen, allergy medications : \_\_\_\_\_

Please describe briefly the dates and results of any problems encountered with:

Hypertension \_\_\_\_\_  
Heart Attack or Heart Surgery \_\_\_\_\_  
Hepatitis \_\_\_\_\_  
Seizures \_\_\_\_\_  
Angina \_\_\_\_\_

Stroke \_\_\_\_\_

AIDS \_\_\_\_\_

Do you have epilepsy? \_\_\_\_\_ Diabetes? \_\_\_\_\_

Migraines? \_\_\_\_\_ Asthma? \_\_\_\_\_

Are your immunizations up to date? \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

Have you had any previous surgeries? If so, please list them below, along with the dates of the procedures and whether there were any complications.

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Please describe your general health condition \_\_\_\_\_

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## RELEASE OF LIABILITY

### I. MINOR CHILDREN

I, \_\_\_\_\_, the parent or legal guardian of \_\_\_\_\_, (Hereinafter referred to as "MINOR") a minor, hereby acknowledge that the Minor is presently under my care and custody. I give permission for the Minor to go to and participate in activities with Covenant Life Church (hereinafter referred to as "CHURCH"), including those activities which require transportation to other locations. (example: camp, small group, outings.)

**THE MINOR IS VOLUNTARILY PARTICIPATING IN THESE ACTIVITIES, INCLUDING TRANSPORTATION TO AND FROM SUCH ACTIVITIES, WITH MY FULL KNOWLEDGE OF THE DANGERS INVOLVED AND HEREBY WE AGREE TO ACCEPT ANY AND ALL RISKS OF INJURY OF SUCH PARTICIPATION AND TRANSPORTATION.**

In the event an emergency arises, necessitating medical or surgical attention, I consent to and give my permission to the Church, its representatives, or trip leaders to make decisions to perform medical treatments and/or surgery upon the Minor which may, in their sole discretion, be necessary and proper under the circumstances.

I understand that I will be financially responsible for any part of the cost of any medical treatments and/or surgery which may be deemed necessary for the Minor to the extent not paid by insurance.

I, the undersigned parent and/or guardian of the Minor, do release, discharge, and agree to hold the Church and its representatives, or trip leaders harmless from any and all claims, actions, damages, and/or liabilities arising out of any accident or sickness, or treatment thereof, incurred by the Minor during activities with the Church.

Signature of parent and/or guardian \_\_\_\_\_ Dated: \_\_\_\_\_

### II. ADULT STUDENTS (To be completed by those OVER 18 years of age):

I, the undersigned, am 18 years of age or older. I have read the above Medical Release Form, including the Waiver, and do agree to the same terms. I release, discharge, and agree to hold the Church and its representatives, or trip leaders harmless from any and all claims, actions, damages, and/or liabilities arising out of any accident or sickness, or treatment thereof, incurred by or for me during activities with the Church.

Signature of participant \_\_\_\_\_ Dated: \_\_\_\_\_