

ELEVATE YOUTH MINISTRY – MEDICAL RELEASE FORM

PLEASE NOTE: This form will be valid for the current school year and following summer (e.g. Sept. 2011-Sept. 2012) after which a new form will be sent out. **If there is any changes to the information during the year, parents (legal guardians) are responsible to communicate those changes to the ELEVATE Youth Ministry staff.**

Child's Name	Birth Date / /
(Last) (First) (Middle)	

Child's Address, City, ZIP	Home Phone
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Parent's E-Mail Address	Sex	M	F	Grade	School
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Mother's Name	Home Phone
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Mother's Address	Cell Phone
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Mother's Employer & Address	Work Phone
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Father's Name	Home Phone
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Father's Address	Cell Phone
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Father's Employer & Address	Work Phone
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PERSONS AUTHORIZED TO PICK UP YOUR CHILD IN CASE OF EMERGENCY

Name	Address	Telephone	Relationship

PHYSICIAN / DENTIST / INSURANCE INFORMATION

Physician	Address	Phone
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Physician	Address	Phone
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Health Plan/Insurance	Subscriber No.	Group No
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Emergency Hospital Preference	Phone
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Alternative action if physician cannot be reached

MEDICAL INFORMATION

Known allergies	Date of Last Tetanus
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Describe continuing medical conditions and medications

PARENT PERMISSION

I hereby give do not give permission for my child to participate in special events, planned field trips, and excursions which may be part of the ELEVATE program. I understand that responsible adults will accompany my child during these activities.

I hereby give do not give permission for my child's photo to be included in American River Community Church & ELEVATE produced materials including printed publications, video productions & the ARCC web site. **Names will not be used.**

Initial↓: In case of emergency, if Parent or Guardian cannot be reached, I authorize a ministry representative to make the necessary arrangements for my child to receive medical or hospital care, including transportation. If my Doctor is not available,

→ I authorize any licensed physician or surgeon to treat my child. Any expense incurred will be accepted by me.

OR

→ I have provided information on my child's health history and agree to accept FULL responsibility for my child's health. I am choosing my right to refuse a medical examination of my child and request that NO medical care be given to my child.

Parent or Guardian's Signature Date Parent or Guardian's Signature Date
Information complies with the California Department of Social Services. Licensing Regulations Sections 101320 and 1011.321.1.