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	
Parent's E-Mail Address		Sex M F	Grade	School

Mother's Name	Home Phone
Mother's Address	Cell Phone
Mother's Employer & Address	Work Phone

Father's Name	Home Phone
Father's Address	Cell Phone
Father's Employer & Address	Work Phone

PERSONS AUTHORIZED TO PICK UP YOUR CHILD IN CASE OF EMERGENCY

Name	Address	Telephone	Relationship

PHYSICIAN / DENTIST / INSURANCE INFORMATION

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

MEDICAL INFORMATION

Known allergies	Date of Last Tetanus
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.