Grace Student Ministries Health and Permission Form

Grace Episcopal Church, 303 S King Street, Morganton, NC 28655
Phone (828)437-1133

Name:_____ **D.O.B**.___/___/___
(Last) (First) (M.I.)

Grade: PreK 1 2 3 4 5 6 7 8 9 10 11 12 College Adult

Gender: Male Female

DRUG ALLERGIES:_____

FOOD ALLERGIES:_____

OTHER ALLERGIES:_____

_____

Parent or Guardian's Information

Name:_____ **Phone:(___)___-____**
(Last) (First) (M.I.)

Address:_____ **Cell:(___)___-_____**
(Street)

_____ **Work:(___)___-____**
(City) (State) (Zip)

Primary Email Address:_____

Permission to Treat:

I,_____, parent or legal guardian of _____(name of youth), authorize the adult leaders of Grace Episcopal Church (Morganton, NC) Student Ministries to act as my agent to consent to emergency transportation, examination, xray, anesthesia, injection, medical, dental or surgical diagnosis or treatment and hospital care as advised and administered by any physician, dentist, or surgeon licensed to practice under the laws of the state where the services are rendered, either at the doctor's office, clinic, or hospital. I understand that every attempt will be made to contact the parent or guardian in the event of emergency. I therefore assume all responsibility for the decisions so made and the emergency care or treatments so secured for my child. I further release Grace Episcopal Church, its staff, adult advisors, and any other leaders from responsibility and liability for any injury or illness that my child may sustain during the youth group events or transportation involving the activities. This document will be valid for one year from the date signed.

_____ _____ _____/___/_____
Parent or Guardian's Name (Please Print) Parent or Guardian's Signature Date

_____ Relationship to Participant

Photo Release: By signing this permission form, you agree that any photographs and/or video taken of your child at or during youth events are the property of Grace Episcopal Church (Morganton, NC) and may be used in future publications (print and electronic) as deemed appropriate.

Health and Medical: (Confidential)

Participant Name: _____ **Age:**_____
(Last) (First) (M.I.)

Gender: Male Female **Date of Birth:** ____/____/_____ **Height:** _____ **Weight:** _____

Health Insurance Carrier: _____

Group: _____ **Identification Number:** _____

May the staff/adult advisors administer to your youth: Tylenol [Acetaminophen] (yes/no), Advil [Ibuprofen] (yes/no), eye ointments (yes/no), antihistamine or decongestant (yes/no), motion sickness medication (yes/no), laxative or antidiarrhea medication (yes/no), antibacterial or antibiotic ointment (yes/no), insect bite or poison oak/ivy ointment (yes/no), Tums/Rolaids [calcium carbonate] (yes/no), Burn ointment or spray (yes/no). **[Note: We will not administer aspirin.]**

Specific directions: _____

_____

Does your youth have any medical condition(s) (medications, etc.) that we should be aware of? Yes No

{If so, please explain on the space provided at the bottom of this page.}

Date of last physical: ____/____/_____ Date of last tetanus shot: ____/____/_____

Swimming Ability: Non-swimmer Beginner/Weak Intermediate/Average Advanced/Swim Team Lifeguard

If parents can't be reached in an emergency,

please contact:_____

Home Phone:(____) _____**Cell Phone:**(____) _____

Relation to Youth: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____