



Name: \_\_\_\_\_

# Youth Medical Form & Emergency Contact Information

For the year: \_\_\_\_\_

## Child's Information

Grade: \_\_\_\_\_ Gender: M F Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Facebook: \_\_\_\_\_

Medical/Health Insurance Provider: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Insurance holder: \_\_\_\_\_

Physician: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Check all that apply:

Glasses/Contact Lenses

Asthma Inhaler: Y N

Epilepsy/Seizure Disorder

Diabetes

Heart Problems

Stomach Problems

Physical Handicaps

High Blood Pressure

Frequent Nosebleeds

## Father's Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Place: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Mother's Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Place: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Place: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Allergies to:

Medications: \_\_\_\_\_

Foods: \_\_\_\_\_

Environmental: \_\_\_\_\_

Other: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

## Medical History

Date of Last Tetanus Shot: \_\_\_\_\_

Are you currently taking any prescription medications?    Y    N

Please list, with explanation and dosage:

Have you had any major illnesses or injuries in the past year?    Y    N    Please List/Explain:

Did any of these result in hospitalization?    Y    N    Please List/Explain:

Any medical conditions that impact participating in events/activities?    Y    N    Please List/Explain:

### Consent for Treatment and Liability Release

This consent form gives permission to seek any medical treatment deemed necessary and releases Our Savior Lutheran Church (OSLC), any OSLC volunteer workers and its staff of any liability against personal injury and losses of named participant.

I, the undersigned, understand that there are inherent risks involved in any ministry and I hereby release Our Savior Lutheran Church, its staff, and volunteers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my involvement. In the event that I am injured and require medical attention, I consent to any reasonable medical treatment as deemed necessary by a licensed medical professional. In the event medical treatment is required as designated by Our Savior Lutheran Church, I agree to hold such person free and harmless of any claims, demands, or suits for damage arising from the giving of such consent. I also acknowledge that I will be ultimately responsible for the cost of any medical care should the cost of that medical care not be covered by the health insurance provider. Further, I affirm that the health insurance information provided is accurate at this date and will, to the best of my knowledge, still be in force.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**[CLICK HERE TO SUBMIT BY EMAIL](#)**

Or save and email as an attachment to: [joelleschaan@gmail.com](mailto:joelleschaan@gmail.com)