

Christ United Church of Christ  
Medical Release Form 2010-11

Name of youth \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth \_\_\_\_\_

Names of parents or guardians to contact in an emergency \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home telephone \_\_\_\_\_ Work \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Name of nearest relative to contact not at above address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home telephone \_\_\_\_\_ Work \_\_\_\_\_

Cell phone \_\_\_\_\_

Allergies (please list all and reaction) \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

Environment \_\_\_\_\_

Insect \_\_\_\_\_

Medicine \_\_\_\_\_

Food \_\_\_\_\_

Medications taken regularly AND use \_\_\_\_\_

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

Health insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

In whose name is the policy? \_\_\_\_\_ Youth carries an insurance card? Y N

Other comments about your child's health \_\_\_\_\_

**In case of emergency, I understand that every effort will be made to contact me. However, if I am not available, I authorize the following people to give permission for medical treatment or sign any form in my absence. (Please name specific people)**

\_\_\_\_\_

This permission form is effective until August 31, 2011.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_