

**St. Paul's Youth Ministry**  
Health Information/Medical Treatment Permission and Release

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

**IN CASE OF EMERGENCY NOTIFY:**

Name: \_\_\_\_\_ Relationship: \_\_\_ Parent  
Address: \_\_\_\_\_ Guardian  
City: \_\_\_\_\_ State: \_\_\_\_\_ Other \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_  
Other \_\_\_\_\_  
Instructions: \_\_\_\_\_

**Health History**

**HAVE OR SUBJECT TO:** (Check if yes)  
 Asthma       Diabetes       Swimming or Sport Restrictions (explain below)  
 Fainting Spells       Convulsions       Allergies or Reaction to Medications (explain below)  
 Heart Trouble       Other (explain below)       Check if none of the above applies  
Describe: \_\_\_\_\_

**HAVE DIFFICULTY WITH:** (Check if yes)  
 Eyes     Ears     Nose     Throat     Lungs     Digestion     Other  
Describe: \_\_\_\_\_

Any condition now requiring regular medication? \_\_\_\_\_ Name of medication \_\_\_\_\_  
Any restriction of activity for medical reason? \_\_\_\_\_  
Describe: \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT**

I understand that I have a duty to provide primary accident and medical insurance for myself (or for my child) and I declare that I am (or my child) is covered by primary accident and medical insurance.

My permission is granted for the Youth Director, minister, Adult Leader or sponsor(s) in charge to obtain necessary medical attention in case of sickness or injury to myself (or my child.)

I, the undersigned, do hereby verify that the above information is correct and I do hereby release and forever discharge all sponsors and employees of St. Paul's Lutheran Church from any and all claims, demands, actions or cause of action, past, present, or future arising out of any damage or injury while participating in any St. Paul's Youth Ministry Sponsored Event.

Insurance Company: \_\_\_\_\_ Insurance/Policy ID Number \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do any pre-certification, notification or other requirements exist with respect to the health insurance? \_\_\_\_\_ If so please specify: \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
Parent/Guardian of Event Participant      Date      Witness

**PARTICIPANT SIGNATURE**

\_\_\_\_\_  
Event Participant      Date      Witness