

Zion's United Church of Christ  
209 Chestnut St.  
Pottstown, PA 19464

Medical/Assumption of Risks and Permission Slip

Name of Youth Participant: \_\_\_\_\_  
Parent/Legal Guardian Name: \_\_\_\_\_  
Home address: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Business Name: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Has this person had any medical problems of which an emergency physician would need to be aware (i.e. but not limited to: asthma, allergy to drugs, food or other, bee stings, chronic illness, headaches, heart ailment, epilepsy, diabetes, physical handicaps, emotional problems, or dietary restrictions)?

YES NO

**If "Yes" please list all conditions/allergies** (food, medication, bee stings, other) and describe:

Should there be any limits on physical activity? YES NO

At the present time, is this person under a physician's care YES NO

If "Yes" please describe:

List dosage and medications you are sending with your child along with why they are taken and any possible side effects: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last Tetanus Booster \_\_\_\_\_

Are there any over-the-counter medications that you **DO NOT** want administered to your child?

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

Is this person covered by medical insurance? YES NO  
Name of Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_  
Is pre-authorization required by your insurance company for emergency services?  
YES NO

If so, what is the phone number of the insurance company? ( ) \_\_\_\_\_

Name of emergency contact person: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Business phone: \_\_\_\_\_

Additional emergency contact: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**PLEASE ATTACH COPIES OF THE FRONT AND BACK OF YOUR CHILD'S INSURANCE CARDS TO THIS FORM.**

*If this person is below the age of legal consent, (18 years) the law requires that we have your permission to give medical service should the need arise. Please read carefully and sign below.*

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all activities except as noted.

I hereby give permission to the Youth Group Leader, \_\_\_\_\_ or his/her designee, to seek routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I request and authorize hospitals and/or other emergency treatment facilities to have access to the information contained in this form in order to provide all necessary medical care for my child. I give permission to the Youth Group Leader or his/her designee to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Youth Group Leader or his/ her designee to secure and administer treatment, including hospitalization, for the person named above. I also agree to assume any financial responsibility for my child's care. I agree to the release of any records necessary for insurance purposes. And, under the new HIPPA code, I give permission to release information to the Youth Group Leader or his/her designee regarding diagnosis, treatment and necessary prescriptions. I acknowledge that no representations, warranties or guarantees as to results or cures will be made. I also understand that there are inherent risks to my child by participating in this event, even with the best of circumstances. With such knowledge I hereby accept such risks, and having read all of the above information, I hereby give permission for my son/daughter to attend church youth group activities.

Print Name: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Parent or Guardian)

Date: \_\_\_\_\_