First United Methodist Church of Gilbert

MEDICAL AUTHORIZATION AND MEDICAL HISTORY

The following information is required to ensure that your youth's individual needs are met while attending all First United Methodist Church of Gilbert's (FUMC-G) Youth Related Events for 2017-2018, your information is confidential and will be made available only to those adults who are directly responsible for your youth's care. For their safety and well-being, no participant will be allowed to attend the EVENT without a completed and signed Medical Authorization and History Form. You may update this form at any time throughout the year by contacting the youth ministry office at 480.892.9166 or youthministry@gilbertumc.org

Student Name _____ Male ☐ Female ☐

Today Date _____ Birth Date _____ Age _____ School Grade _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Youth Cell Phone _____

Youth E-mail _____

Parent #1 Name _____ P1 Cell _____

P1 E-mail _____

P1 Home Phone _____ P1 Work Phone _____

Parent #2 Name _____ P2 Cell _____

P2 E-mail _____

P2 Home Phone _____ P2 Work Phone _____

If parents cannot be reached in an emergency, please contact

Name _____ Relationship _____

Home Phone _____ Emergency Work Phone _____

Emergency Cell Phone _____

Family Primary Physician _____ Physician Phone _____

Insurance Carrier/Plan Name _____ Policy ID #: _____

Carrier Address _____

Release Statement

(Name of Participant) _____ has my permission to attend all First United Methodist Church of Gilbert (FUMC-G) youth-related events for 2017-2018. In case of medical or surgical emergency, I hereby authorize the physician selected by the staff or youth advisors of FUMC-G to secure all proper and required treatment for my child.

_____ Check here if you **DON'T** want your child to be photographed during FUMC-Gilbert youth events.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Medical Release Notary
Subscribed and sworn to me on this day of: _____ _____ _____

My Commission Expires: _____ _____ _____
Month Day Year

X_____
Notary Signature

Notary Stamp

MEDICAL HISTORY

Please list any physical or behavioral conditions that program staff should be aware of (i.e. sleepwalking, bedwetting (please send an easily laundered sleeping bag), epilepsy, fainting, asthma, hyperactivity, nose bleeds, etc.). Please be specific:

_____

_____

_____

Allergies:

_____ Food *(List particular allergy and explain)* _____

_____

_____ Medication *(List particular allergy and explain)* _____

_____

_____ Insect bites *(List particular allergy and explain)* _____

_____

Is the Participant a vegetarian/vegan? Yes _____ No _____ Vegan? _____

Is the Participant currently taking any medication? Yes _____ No _____

If "Yes", please list all medications that the Participant will be bringing, including complete instructions for administering. Medications must be checked in with the Health Supervisor at time of departure and must be in their original containers. All medications will be dispensed by the Health Supervisor or Youth Director (Ryan Collins)

Name of Medication _____

Instructions _____

_____

Name of Medication _____

Instructions _____

_____

Date of Participant's last physical examination: _____

Is the Participant currently under the direct care of a physician for any medical condition, recent surgery, or illness?

Yes _____ No _____ If "Yes", please explain _____

_____

Is Tetanus shot current?: _____

May the Health Supervisor administer any of the following to the Participant? *(Check box Y for Yes or N for No to each.)*

☐ Y / N ☐	Ibuprofen (i.e. Motrin)	☐ Y / N ☐	Insect bite or poison oak ointment
☐ Y / N ☐	Acetaminophen (i.e. Tylenol)	☐ Y / N ☐	Antibacterial or antibiotic ointment
☐ Y / N ☐	Eye ointments	☐ Y / N ☐	Antacid
☐ Y / N ☐	Antihistamine or decongestant	☐ Y / N ☐	Cough drops / syrup