

# 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, 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 ( ) \_\_\_\_\_  
E-mail \_\_\_\_\_  
Parent #1 Name \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
E-mail \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Parent #2 Name \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
E-mail \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

### If parents cannot be reached in an emergency, please contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_  
Family Primary Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Insurance Carrier/Plan Name \_\_\_\_\_ Policy ID #: \_\_\_\_\_  
Carrier Address \_\_\_\_\_

### Participation and Volunteering Release Statement

(Participant Name) \_\_\_\_\_ has my permission to travel with and/ or attend ALL First United Methodist Church of Gilbert (FUMC-Gilbert) events. In case of medical or surgical emergency, I hereby authorize the physician selected by the staff, youth director or youth advisors of FUMC-Gilbert to secure all proper and required treatment for my child. I am aware that volunteering and participation may be a potentially hazardous activity and I acknowledge that these potential hazards have been explained and discussed and I hereby waive, release and discharge any and all claims of damages for death, personal injury or property damage which I/we may have.

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

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## MEDICAL HISTORY

Please list any physical or behavioral conditions that the 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:

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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, Youth Director, Youth Leader or assigned adult.

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? (*Circle 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