MEDICAL HISTORY FORM

All youth, youth directors, advisors, and all adults attending events must fill in this form.

Name (last, first):____
Date of Birth:________________________**Age:**________**Grade (Fall 2018):**__________
Address____
City:__________________________**State:**__________ **Zip:**________________
Mother's Name____________________________**Mobile #:**__________________
Father's Name____________________________**Mobile #:**__________________

Physician's Name____________________________________ **Tel#:**______________
Dentist's Name_____________________________________ **Tel#:**______________
Hospital of Choice: _________________________________ **Tel#:**______________
Any medical problems ?____
Is your child taking either prescription or over-the counter medication on a regular basis? Yes/ No
Name of drug/ dose/ time of day it is taken______________________________
Does child have any drug allergies? Yes / No
If yes, Name of Drug(s):____
Other Allergies:____
Type of Reaction (be specific):_______________________________________
Comments:____

List names and telephone numbers of two persons to contact if your child is ill or injured. In the event that the parent or guardian cannot be contacted, these persons may have to make a medical decision.

1. Name______________________**Relationship**__________ **phone**__________
2. Name______________________**Relationship**__________ **phone**__________

EMERGENCY MEDICAL TREATMENT

I the undersigned agree(s) that in the event that I am unable to be reached and my child needs EMERGENCY MEDICAL TREATMENT during any time he/she participates in this retreat, you have my permission, and I hereby designate you my agent, to act in my son's/daughter's best interest in obtaining necessary transportation and medical care until I can be contacted. I hereby release you from any claim arising out of your and the doctor's actions relating to my child's illness/injury, and I assume and agree to pay for any professional medical services and other fees/costs incurred.

RELEASE OF LIABILITY

The undersigned agree(s) that St. John the Divine Greek Orthodox Church shall have no liability for any claims for losses, damages, costs, or expenses incurred or arising directly or indirectly from any acts or events which may occur during Vacation Bible School, from June 17-21, 2013.

Parent/Guardian Signature:______________________________________**Date**__________

Permission for emergency medical treatment will be effective throughout the youth's enrollment. If there is any change of information, please contact either the clergy or advisors.

Name of Insured:____

Insurance Company____

Group Identification # : _____________________**Member #** _________________

Telephone # ____

____**Attached is a copy (front and back) of the Insurance Card of the Insured—stapled to this form**