

Registration/Medical Release Form

Event Name: _____

Event Date: _____

OFFICE USE ONLY		
AMOUNT PAID \$	_____	
CHECK #	CASH	Pay Pal
_____	_____	_____
MEDICAL CARD ATTACHED	Yes	No
_____	_____	_____

First Name: _____ **Last Name:** _____

Address: _____ **City/State:** _____ **Zip** _____

Parents/Guardian Name: _____ **Phone:** _____ **Cell Phone:** _____

Female ____ **Male** ____ **Birthdate (mm/dd/yyyy):** _____ **Grade:** ____ **Age:** ____ **Group Travel: Yes/No**

Church Name: _____ **Email:** _____

EMERGENCY & HEALTH INFORMATION (To be completed by parent/guardian):

General: Does the Youth Have (If "Yes" Explain):

YES **NO** **Allergies?** _____
 YES **NO** **Heart Condition?** _____
 YES **NO** **Other?** _____

Is Youth Subject to (If "Yes" Explain):

YES **NO** **Fainting?** _____
 YES **NO** **Sleep Walking?** _____
 YES **NO** **Upset Stomach?** _____
 YES **NO** **Other?** _____

Does the Youth Have Reaction to (If "Yes" Explain):

YES **NO** **Bee Stings?** _____
 YES **NO** **Penicillin?** _____
 YES **NO** **Other Drugs?** _____
 YES **NO** **Peanuts?** _____
 YES **NO** **Other?** _____

Date of Last Tetanus Shot: _____

Please indicate ANYTHING else which the Leadership should know to help avoid or assist any situation with may arise: _____

EMERGENCY INFORMATION:

Insurance Company: _____ **Policy Number:** _____

Contact People: Parents Work Phone: _____ **Friend/Relative Phone:** _____

Doctor's Name: _____ **Doctor's Phone:** _____

Dentist's Name: _____ **Dentist's Phone:** _____

EMERGENCY PROCEDURE: IN THE EVENT OF AN EMERGENCY, THE YOUTH SPONSORS WILL ATTEMPT FIRST TO CONTACT THE PARENT. If that is impossible check below:

- YES** **NO** **1. With my signature I herby authorize First Aid by Pastors or Youth Sponsors.**
 YES **NO** **2. With my signature I herby authorize emergency medical care by hospital staff and/or doctor selected by Pastors of Youth Sponsors.**
 YES **NO** **3. With my signature I herby authorize physician selected by Pastor or Youth Sponsors to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery.**

If parent has answered "NO" to either #1, #2 or #3 above, YOU MUST indicate procedure to be followed in the event we are not able to contact parent/guardian: _____

Parent/Guardian Signature: _____ **Date:** _____

(Please attach a copy of the front and back of your Medical Insurance Card)