DERWOOD ALLIANCE CHURCH

Transform Empower Launch

MEDICAL RELEASE

Student's Name: _____ D.O.B. :_____

Address: _____

Parents'/Guardians' Names: _____

Cell Phone: _____ Home Phone: _____

Address (if different from child's): _____

Insurance Company: _____ Policy #: _____

1. Is your child allergic to:

   _____ bee sting _____ pollens _____ other drugs: _____

   _____ hay/straw _____ penicillin _____ other: _____

2. Does your child have any life-threatening allergies? _____ Yes _____ No

   If yes, to what? _____

3. Is your child bringing any medication with him/her? _____ Yes _____ No

   If yes, please list and state dosage: _____

   PLEASE NOTE: Medication should be in its original prescription bottle/package, which should have administration instructions and the child's name clearly indicated.

4. Does your child have your permission to self-administer this medication? _____ Yes _____ No

5. Does your child have any physical, emotional. Mental or behavioral concerns or limitations that our staff should be aware of? _____ Yes _____ No

   If yes, please explain: _____

6. Has your child ever had:

   _____ seizures _____ asthma _____ diabetes

   _____ homesickness _____ heart disease _____ other: _____

7. Date of last tetanus shot: _____

In the case of medical emergency, I understand that hospital policy requires parental permission before treatment. I hereby give my permission to a representative of Derwood Alliance Church to administer medication as identified above (see #3) and to secure proper medical treatment. *Parents will be notified immediately of any medical emergency.*

Signature of Parent/Guardian: _____ Date: _____

Emergency Phone : _____

Person to contact if parent/guardian cannot be reached: _____

Relationship to child: _____ Phone: _____