SOTWC YOUTH
MEDICAL RELEASE FORM

Name_____

Address _____

City/State/Zip _____

Birthday_____ Age_____

Parent/Guardian Name _____

Address _____
(if different from above)

City/State/Zip _____

Employed by_____

Daytime Phone (_____) _____ Evening/Night Phone (_____) _____

Are you currently taking medicine or treatment? □ Yes □ No
If yes, explain_____

Have you been restricted from sports or swimming for any reason? □ Yes □ No
If yes, explain_____

Date of last Tetanus Immunization: Month_____ Year_____

Have you ever had a severe reaction to a bee/hornet sting, or insect bite? □ Yes □ No
If yes, explain _____

Do you have:
□ Sinus Trouble
□ Hay Fever
□ Heart Trouble
□ Epilepsy
□ Asthma
□ Diabetes

List Any Allergies:
Food:_____

Drugs: _____

Other Medical Needs:_____

_____

EMERGENCY MEDICAL AUTHORIZATION

In the event of an emergency, I hereby give permission to the church-appointed sponsors who are with my child to obtain medical assistance for my child. I also give permission to the physician selected to hospitalize and secure proper treatment for my child.

Parent/Guardian Signature:_____

Insurance Company: _____

Policy Number:_____

If I cannot be reached, please notify: _____

(_____)_____ or (_____) _____