CALVARY CHAPEL ANTELOPE VALLEY YOUTH MINISTRIES

EMERGENCY MEDICAL RELEASE FORM

CALVARY CHAPEL ANTELOPE VALLEY
1833 WEST AVENUE J
LANCASTER, CA 93534
661.942.0404

REQUIRED FOR ALL YOUTH EVENTS

Name _____ Birth Date ____/____/____ Age _____

Address _____

Phone# __(_____)_____ Cell Phone# __(_____)_____

Physician Name _____ Phone# __(_____)_____

Medical Insurance Company _____ Policy # _____

Parent/Guardian Name _____ Relationship _____

Phone# __(_____)_____ Cell Phone# __(_____)_____

Parent/Guardian Name _____ Relationship _____

Phone# __(_____)_____ Cell Phone# __(_____)_____

Other Emergency Contact _____ Relationship _____

Phone# __(_____)_____ Cell Phone# __(_____)_____

AUTHORIZATION FOR MEDICAL TREATMENT OF MINOR

If a serious accident or illness befalls your child, a representative of Calvary Chapel Antelope Valley will make every effort to call you and/or one of the above contacts, and comply with any instructions for required treatment. If we are unable to contact any of the above emergency contacts, Calvary Chapel Antelope Valley is authorized to contact the physician listed above and/or transport your child to a local hospital/medical treatment facility for necessary medical care.

I, the undersigned hereby give consent for any procedure or hospital care deemed advisable by medical provider. I also authorize Calvary Chapel Antelope Valley to give necessary consent for any treatment, care, diagnosis or examination of the above named child in an emergency situation. A representative of Calvary Chapel Antelope Valley may also administer any necessary over-the-counter medication and/or listed prescriptions to my child. I hereby release Calvary Chapel Antelope Valley, its leadership, representatives, and agents from all liability for any injury, death, or damage while my child is participating in or being transported to and from a youth fellowship activity. These authorizations shall remain effective through **December 31, 2016**, unless sooner revoked in writing and delivered to a representative of Calvary Chapel Antelope Valley.

Parent/Legal Guardian Signature (Required) _____Date_____

Minor Signature (Also Required) _____Date_____

Health History

Does your child have any of the following medical problems? (List any details)

□ Bleeding/Clotting Disorder_____

□ Frequent ear Infections_____

□ Heart Problems_____

□ Convulsions_____

□ Diabetes_____

□ Sleep walking_____

Major Operations or serious injuries (list)

□ _____

□ _____

□ _____

□ _____

Allergies

□ Asthma_____

□

□ Food Allergies_____

□ Airborne allergies_____

□ Insect stings_____

□ Penicillin allergies_____

□ Other drug allergies_____

□ _____

□ _____

Has your child had any of the following? (Please give approximate date)

□ Chicken Pox_____

□ Measles_____

□ German Measles_____

□ Mumps_____

□ Other_____

□ Other_____

Does your child have any health factors that possibly limit his/her physical activity?

Yes____ No_____ If Yes, Please Explain:_____

_____

Please list any medications that your child is taking or may need to take while with us:

Medication Names	Dosage/Times Daily	Medical Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____