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CALVARY CHAPEL ANTELOPE VALLEY YOUTH MINISTRIES  
**EMERGENCY MEDICAL RELEASE FORM**

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CALVARY CHAPEL ANTELOPE VALLEY  
1661 West Lancaster Blvd  
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, 2026**, 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

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

- |                                    |                       |
|------------------------------------|-----------------------|
| ♣ Bleeding/Clotting Disorder _____ | ♣ Convulsions _____   |
| ♣ Frequent ear Infections _____    | ♣ Diabetes _____      |
| ♣ Heart Problems _____             | ♣ 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
_____	_____	_____
_____	_____	_____
_____	_____	_____