

# MEDICAL RELEASE

Valid from August 1, 2009 to July 31, 2010

## Medical Release and Health History form for FX Student Ministries

Faith Evangelical Free Church  
3920 S. Shields St., Fort Collins, CO 80526

To be filled out by parent/guardian of minor or by adult volunteer/participant/staff.

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Last First In

Parent or Guardian (or spouse): \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street & Number City & State Zip

Business Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Street & Number City & State Zip

If not available in an emergency, notify:

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Street & Number City & State Zip

Do you carry medical/hospital insurance? \_\_\_\_\_ If so indicate:

Carrier: \_\_\_\_\_ Policy or Group#: \_\_\_\_\_

### **PLEASE ATTACH COPY OF INSURANCE CARD – FRONT & BACK TO THIS FORM!**

**If you are traveling out of the USA for church sponsored events make sure to receive whatever appropriate preventive medications are deemed necessary by the US Health Department for the area of the world in which you will be serving.**

**IMMUNIZATION HISTORY:** Date of last immunization for:

Tetanus: \_\_\_\_\_ Pertussis: \_\_\_\_\_ Diphtheria: \_\_\_\_\_ Polio: \_\_\_\_\_ Measles: \_\_\_\_\_

### **HEALTH HISTORY:**

#### **ALLERGIES**

- Food
- Drugs
- Asthma
- Hay Fever
- Insect Stings
- Other \_\_\_\_\_

#### **OTHER HEALTH CONDITIONS**

- Diabetes
- Cardiac
- Chronic Asthma
- Nervous Disorder
- Epilepsy
- Physical Handicap

- Emotional handicap
- Mental handicap
- Seizure Disorder
- Altitude restrictions
- Other \_\_\_\_\_

If you have checked any of the above, please give details: \_\_\_\_\_

Activity Restriction (s): \_\_\_\_\_

### **IMPORTANT– THIS BOX MUST BE COMPLETED FOR FEFC EVENT ATTENDANCE**

My child has permission to participate in all church events, except as noted above. I hereby give permission to the medical personnel selected by the FEFC event director to order X-rays, routine tests and treatment for the health of my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician, nurse or dentist selected by the event director to hospitalize, secure proper treatment (including surgery, injection and/or anesthesia) for my child as named above, to include transportation to and from the necessary facilities. This health history is correct so far as I know.

\_\_\_\_\_  
Signature of parent or guardian or adult volunteer/participant/staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Minor

\_\_\_\_\_  
Date

**You will be informed if a Physician's Exam and Signature is necessary for specific church events.**