GRACE COMMUNITY CHAPEL
MEDICAL CONSENT FORM 2021/2022 SCHOOL YEAR

Child's Name (Last, First) _____

Address _____ City _____ State _____ Zip _____

Child's Cell Phone _____ Date of Birth _____ Sex: M _____ F ____

Optional Secondary Contact (other than below parent)_____ Phone _____

PHYSICAL CONDITION (Check if condition needs special attention and specify.)

_____ Frequent Colds
_____ Asthma
_____ Diabetes
_____ Eye, ear, nose, throat
_____ Allergies- please list _____
_____ Heart condition
_____ Stomach upsets
_____ Epilepsy or other nervous system disorder

Others/Explanation: _____

_____

_____

Please list any daily medication(s) your son/daughter is taking on a daily basis AND the dosages.
(This is for anything we might have to regulate during trips or overnight events.)

_____

_____

_____

_____ **INITIAL HERE** if you give your consent for the Youth Staff to administer "over-the-counter" (OTC) medications to your son/daughter as they deem necessary (i.e. ibuprofen, anti-acid, etc.).

Date of last Tetanus shot _____ Are all Vaccines up-to-date _____

Any swimming restrictions: Yes _____ No _____

Any activity restrictions: Yes _____ No _____ (give details on back of this form)

Insurance Company _____ Policy Number _____

I/we, the undersigned parent(s) (or legal guardian) of _____(MINOR), do hereby authorize the youth sponsor/church staff member for the undersigned to consent to any X-ray, anesthetic, medical or surgical diagnosis of, treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician and/or surgeon on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital, and I/we hereby waive, release, absolve, indemnify and agree to hold harmless Grace Community Chapel, sponsors, supervisors, organizers, youth sponsor and/or church staff member for any claims out of an injury to my/our child, except to the extent and in the amount covered by accident or liability insurance.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required and is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. I know of no health reason why my son/daughter may not participate in any Youth Department activities.

SIGNATURE: _____ Date: _____

Printed Name: _____

Address (if different from student): _____

Home Phone: _____ Cell Phone: _____