

APPENDIX I - Medical History and Release Form

I/we, being the parent(s) or legal guardian(s) of the below named child under the Age of 18 or developmentally disabled adults, understand that hospital policy requires parental permission before treatment. I hereby give my permission to a representative of Maranatha Bible Chapel to administer medication as identified below (see #3) and to act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization during events, outings, and other church sponsored activities. This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as such care may be required. This instrument shall remain effective for one year, or until revised or withdrawn. *Parents will be notified immediately of any medical emergency.*

Student's Name: _____ Date of Birth: _____

Address: _____ Phone: () _____

Parent(s)/Guardian(s) Names: _____

Address (if different from child's): _____

Physician Name _____ Address _____ Phone _____

Insurance Company: _____ Policy or ID #: _____

1. Is your child allergic to:
_____ bee stings _____ pollens _____ drugs/medications _____ hay, straw
_____ penicillin _____ other explain: _____

2. Does your child have any life- threatening allergies? ____ Yes ____ No If yes, to what? _____

3. Is your child bringing any medication with him/her? (Note: The term "medication" includes aspirin and other non-prescription pain relievers, medicated powders, ointments, and lotions) ____ Yes ____ No If yes, please list and state dosage.

PLEASE NOTE: Medication should be in its original prescription bottle/package, which should have administration instructions and the child's name clearly indicated. Parents are strongly encouraged to administer medications prior to taking children to classes or events. Medications are NOT administered by volunteer staff except in an emergency. Except for medications listed herein, children are not permitted to possess or take medications.

4. Does your child have any physical, emotional, mental or behavioral concerns or limitations that our staff should be aware of?
____ Yes ____ No If yes, please explain:

5. Has your child ever had:
_____ seizures _____ asthma _____ diabetes _____ homesickness _____ heart disease _____ other _____

6. Date of last tetanus shot: _____

Signature of Parent/Guardian: _____ Date: _____

Emergency Phone: () _____

Contact person if parent/guardian unreachable: _____ Relationship: _____ Phone: _____