FCCB Youth Program Medical Release Form

To be completed annually (State form may be submitted instead)
Date Completed _____

Name of Youth _____ Birthdate _____

Address_____

Name of parent or guardian _____

Best phone number to reach you _____

Youth's physician _____ Phone _____

Emergency contact _____ Phone _____

Emergency contact _____ Phone _____

Health History (Please check all that apply)

- ☐ Frequent colds
- ☐ Appliances (retainers
- ☐ contact lenses, etc.)
- ☐ Sleep disturbances
- ☐ Emotional/behavioral disability
- ☐ Seizure Disorders
- ☐ Stomach upsets
- ☐ Mental disability
- ☐ Vision/hearing impairment
- ☐ Physical disability
- ☐ Diabetes
- ☐ Asthma
- ☐ Motion sickness

- ☐ Other

  _____

- ☐ Allergies

  _____

If any of the above is checked, please give important details

_____

_____

Date of last Tetanus shot

_____

Has your child been vaccinated for Covid-19? _____

If so, the dates of the 1st and 2nd vaccinations _____

Is your child/youth taking a prescription or non-prescription medication?

- ☐ Yes
- ☐ No

If Yes, please list medications, dosage and frequency and reason for medication:

_____

_____

_____

_____

_____

Can your son/daughter be expected to take the right amount of medication at the proper time? If the answer is no, arrangements must be made with the adult in charge.

- ☐ Yes
- ☐ No

- ☐ I give my child permission to administer his/her own medications.

_____

Signature of parent/guardian

Youth's insurance carrier & policy number

_____

Name of primary insured

_____

Other pertinent information

_____

_____

_____

STATEMENT OF CONSENT

I, the undersigned, parent/legal guardian of_____, do hereby consent to any x-ray exam, anesthetic, medical diagnosis or treatment and hospital services that may be rendered to said minor, under the general or specific instructions of

_____

(name of youth's physician)

or, if unavailable, two on-call physicians at a hospital or clinic. It is understood that this consent is given in advance of any specific diagnosis or treatment and is given to encourage those persons who have temporary custody of my child, in my absence, and said physician to exercise their best judgment as to the requirements of such diagnosis or said medical treatment.

This consent will remain effective for 12 months from initial submision to said persons entrusted with the care, custody and control of said minor child. I understand that any and all medical expenses incurred are my responsibility and that there is not medical insurance coverage provided by First Congregational Church, Branford, CT

_____

Signature of Parent/Guardian Date

For Office Use:

Date Received: _____

Reviewed by: _____

Questions/Concerns Addressed with Parent/Guardian Yes No