

# STUDENT RELEASE & MEDICAL FORM

Effective Dates: \_\_\_\_\_ – December 31, 2018  
TODAY'S DATE

## Student Information:

Name: \_\_\_\_\_ Birthday (M/D/Y): \_\_\_\_\_  Male  Female  
LAST FIRST MIDDLE

School: \_\_\_\_\_ Current Grade: \_\_\_\_\_ Student's Email: \_\_\_\_\_

Student's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Student's Home Phone: \_\_\_\_\_ Student's Cell Phone: \_\_\_\_\_

## Parent/Guardian Information:

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Mother's Email: \_\_\_\_\_

Mother's Address (if different than student's): \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Father's Email: \_\_\_\_\_

Father's Address (if different than student's): \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do both parents have custody?  Yes  No If not, who is the custodial parent/guardian? \_\_\_\_\_

## Emergency Contact Information:

Parents will be the first contact. However, in the event parents cannot be reached, we will inform the following people:

Full Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

## Insurance Information

Medical Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Primary Care Doctor/Provider: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Office Phone: \_\_\_\_\_

## Health History

(Please check all that apply)

- \_\_\_\_\_ Seasonal Allergies  
\_\_\_\_\_ Frequent Ear Infections  
\_\_\_\_\_ Heart Defect/Disease  
\_\_\_\_\_ Blood Disorders  
\_\_\_\_\_ Psychiatric Treatment  
\_\_\_\_\_ Mononucleosis  
\_\_\_\_\_ Hypertension  
\_\_\_\_\_ Seizures/convulsions  
\_\_\_\_\_ Diabetes  
• On insulin?  Yes  No  
• Glucose Testing?  Yes  No  
\_\_\_\_\_ Asthma  
• Use of inhaler?  Yes  No  
\_\_\_\_\_ Other conditions not listed above

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medications:

Please list any medications taken routinely, along with the dosage and frequency.

Medicine 1:

Medicine 2:

Medicine 3:

## Allergies

(Please be as specific as possible)

- \_\_\_\_\_ Insect Stings/Reactions: \_\_\_\_\_  
\_\_\_\_\_ Food Allergies/Reactions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Medication Allergies: \_\_\_\_\_  
\_\_\_\_\_ Prescribed EpiPen  
• Can student self-administer EpiPen?  Yes  No

## Over-the-Counter Medicines

Do we have your permission to give your student Acetaminophen or Ibuprofen according to the prescribed dosages listed on the bottle if they complain of minor headaches, cramps, or other aches/pains?

Yes  No

## Other Medical Information

Basic first aid will be administered as needed, unless noted by the parent. Please explain below if you wish to decline.

Does your student wear: Glasses Contact Lenses

Date of last tetanus shot: \_\_\_\_\_

Approximate Height: \_\_\_\_\_ Approximate Weight: \_\_\_\_\_

Please explain if this student's activities should be restricted for any reason:  
\_\_\_\_\_  
\_\_\_\_\_

## Parental Consent & Waiver

I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events organized by Harvest Bible Chapel Lancaster - Myerstown Campus (hereinafter the "Church"). I/We understand that there are inherent risks involved in any activity (typical Harvest Students activities include but are not limited to youth group games, gagaball, kickball, other similar activities, and occasional swimming), and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our student's transportation to and from the event (if provided by Harvest Bible Chapel Lancaster - Myerstown Campus) and their involvement in it. In the event that he/she is injured and requires the attention of a medical professional, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. This consent form gives permission to seek whatever medical attention is deemed necessary, and releases Harvest Bible Chapel Lancaster - Myerstown Campus and its staff of any liability against personal losses of named student. Every effort will be made to ensure the safety of your student; however, accidents and injuries may occur even when precautions are taken. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by my health insurance provider.

I also agree to place my student in the care of Harvest Bible Chapel Lancaster - Myerstown Campus' staff and volunteers, understanding that my student is subject to the Church's rules and regulations. I understand that, if my student fails to adhere to any verbal or written rules, the staff and volunteers reserve the right to send my student home and not refund any money that may have been collected for an activity.

I give my permission for any photographs or video taken of my student in conjunction with Harvest Bible Chapel Lancaster - Myerstown Campus to be used in any highlight presentations, Sunday morning worship services, and/or future promotional materials.

## PRIVACY POLICY:

Harvest Bible Chapel Lancaster - Myerstown Campus values your privacy and will not sell, rent, or otherwise give out your personal information (including photographs or videos of your student) for use outside of Harvest Bible Chapel purposes.

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_