NAME: Staff Volunteer Participant (circle one)

MEDICAL HISTORY AND RELEASE FORM

Ceres Christian Church

PERSONAL INFORMATION

Applicants name (print): Last	First	Middle
Street Address:		
City:	State:	Zip:
Telephone: ( )	E-mail:	
Birth Date: / /	Sex: Female □ Male □	

Parent/Guardian: Relationship:

Telephone: ( ) ( ) ( )

home work other

Parent/Guardian/Emergency Contact: Relationship:

Telephone: ( )) ( ) ( )

home work other

INSURANCE INFORMATION

The Church's no-fault accident insurance is limited and secondary to any other col ectible insurance. Please furnish the following medical and insurance coverage information:

Insurance Company:		Policy or Group #:	
Social Security No. of Policyholder or Insurance ID Number:			
Insurance Phone # ( ) Address:			
Family Physician:		Phone# ( )	
Address:			
Family Dentist/Orthodontist		Phone# ( )	

MEDICAL HISTORY

Many activities require participating in physical exercises that are physically demanding. Do you have health problems or disabilities that might hinder you from participating fully in youth activities: □ Yes □ No

If yes, please describe in detail (attach additional sheet if necessary)

Do you have any allergies (including medicine, food, or other substance allergies) - please list below? Would your allergy affect participation in Youth activities?: □ Yes □ No If yes, please explain (attach additional sheet if necessary):

List any ongoing medical care or medications (including over-the-counter or other nonprescription drugs) you are taking (if none, state "NONE"):

Medication	Dosage		Frequency	Reason for Taking
Health History - Explain any "yes answers below:				

Has/does participant:	YES	NO		YES	NO
1. Had recent injury, illness, infectious disease?	_____	_____	5. Have problems with sleepwalking?	_____	_____
2. Have a chronic or recurring illness/condition?	_____		6. Have a current history of bed-wetting?	___	_____
3. Have frequent headaches?	___	_____	7. Have an eating disorder?	___	_____
4. Wear glasses/contacts?	_____		8. Ever had seizures?	_____	

Last Tetanus shot: _____ (date) _____

ADULT APPLICANT: I certify that to the best of my knowledge this health history is correct and complete, that I am in good health and able to participate in CCC youth activities except as noted.
Adult applicant signature _____ Date _____

PARENT/GUARDIAN AUTHORIZATION: This health history is correct and complete and the person herein described has permission to engage in all CCC Youth Group activities except as noted. I understand that if any statement in this Medical Form is false, misleading, incorrect, or the Church is unable, in its sole judgment, to properly care for or protect my child (due to his/her medical condition), he/she may be sent home at my expense.
Parent Signature _____ Date _____

IMPORTANT - These boxes must be completed for attendance

Permission to provide necessary treatment or emergency care:

I hereby give permission to available CCC staff and volunteers or available medical personnel to administer prescribed medications and provide routine health care, including over-the-counter medications, to my child as deemed necessary. In the event of an accident/illness, I consent to the administration of emergency on-site first aid. If I cannot be reached in an emergency, I hereby give permission to the CCC staff and volunteers to secure and administer treatment, including hospitalization, for the person named above. This authorization includes consent to any medical, emergency dental, surgical, chiropractic or hospital diagnosis, treatment or care to be rendered to or for me/my child under the general or specific supervision of a qualified physician, surgeon, chiropractor or dentist. It also includes permission to release any records necessary for supervision, treatment, referral, billing or insurance purposes and to provide or arrange necessary related transportation. I understand and agree that the foregoing will be at my expense. This consent shall terminate without further notice on the date when a minor reaches 18 years of age. This completed form may be photocopied for trips.

Parent/guardian or adult participant signature_____

Printed name _____ Date_____

If medication for life-threatening conditions is brought to camp (epi pen, inhaler, etc.), I hereby request that said medication remain with □ CCC staff/volunteers _____ **□ My child** _____

I understand that accommodating some medical conditions or disabilities may not be ideal and may differ depending on the activity. Therefore, if I am accepted, I agree to abide by any restrictions which may be placed on my activities that CCC staff and volunteers feel are necessary for my comfort or safety or that of my fellow participants or staff/volunteers.
Participant signature: _____Date_____

SPECIAL NOTE ABOUT MEDICATIONS:

Please not that if participant brings ANY medications, including all prescription, over-the-counter and herbal remedies, the following rules will need to be followed:

1. All medications must be in their original packages, i.e. prescriptions in the prescription bottle, Tylenol in the Tylenol bottle, herbs in the bottle that they were originally bought in.
2. All medications must be accompanied by written and signed instructions for administration (the prescription on the bottle will be sufficient unless doses or times have changed).
3. Any nonprescription bottles must have the participant's name written on them (prescription bottles must be for the participant. PLEASE help us take good care of the precious and wonderful youth that you have entrusted us with.