

**Medical Release Form**  
**Mount Olive Lutheran Church Youth Ministry**  
**1989 East Calaveras Blvd. Milpitas, CA 95035 (408) 262-0506**

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City Zip Code

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F Home phone # \_\_\_\_\_

FATHER: \_\_\_\_\_  
First Name Last Name Home phone # work or cell. #

MOTHER: \_\_\_\_\_  
First Name Last Name Home phone # work or cell. #

GUARDIAN: \_\_\_\_\_  
First Name Last Name Home phone # work or cell #

INSURANCE: \_\_\_\_\_ Policy #: \_\_\_\_\_

DR. \_\_\_\_\_  
Name Office Address Telephone

While my child is attending or traveling to or from any Mount Olive event, I HEREBY AUTHORIZE THE ADULT LEADER, or in his/her absence or disability, any adult accompanying or assisting him/her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR SAID MINOR:

Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code Section 2000 et seq.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. **This authorization shall remain effective until December 31, 2010** unless sooner revoked in writing. It is understood that an effort shall be made to contact the undersigned prior to the rendering of treatment, but such treatment will not be withheld if the undersigned cannot be reached. I will not hold Mount Olive Church or its staff and counselors liable for medical aid rendered or consent given for diagnosis/treatment of my child. I understand that as a parent/guardian, I will be responsible for the cost of any service or treatment.

I also grant permission for photographs and video clips to be taken of the above named child, and I understand that these pictures may be viewed by the public

**EMERGENCY CONTACT INFORMATION**

**In the event of an emergency and parents/guardian cannot be reached, please contact:**

(1) \_\_\_\_\_  
Name Address Telephone Relationship

(2) \_\_\_\_\_  
Name Address Telephone Relationship

**AUTHORIZATION AND CONSENT AND RELEASE**

I hereby certify that my child is in good health and can travel to and participate in all Mount Olive Youth Functions.  
I understand it is my responsibility to keep the information on this form updated.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

# Health History Information

\_\_\_\_\_

First Name

\_\_\_\_\_

Last Name

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth

Subject to:	YES	No	Now Have or Have Had	Yes	No
Colds/Sore throat?			Asthma?		
Sinus Trouble?			Lung Trouble?		
Bronchitis?			Heart Trouble?		
Fainting Spells?			Intestinal problems including diarrhea, constipation, etc.?		
Convulsions (seizures)?			Hernia (rupture)?		
Cramps?			Appendix removed?		
Headaches/Migraines?			Sleep walking?		
Wear corrective lenses?			Ear, nose, or throat complications?		
Is hearing impaired?			Diabetes?		
Currently under any type of medical care?					
Is there history of behavior disorders, emotional disturbances, or severe moodiness?					
Been under psychiatric treatment within the past five years?					

Please explain yes answers or list other disabilities or disorders that may affect participation, such as: eyesight, hearing, speech, paralysis, ulcer, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Remarks and special instructions to aid child.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of last Tetanus Vaccination: \_\_\_\_\_

Please list all current medications:

Name of Medication	Dosage	Times Taken

Please check over-the-counter medications that may be administered:

- Tylenol   
  Ibuprofen   
  Cough Syrup   
  Decongestant   
  Dramamine  
 Antacid   
  Polysporin   
  Hydrocortisone   
  Benadryl   
  Other: \_\_\_\_\_

Please identify allergies including allergies to food, medications, and drug reaction and explain the reaction: i.e. hives, difficulty breathing, nausea, anaphylaxis, etc

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_