

Shenkel UCC Youth Information Sheet

Valid through September 30, 2010

Please inform Shenkel UCC if any changes occur prior to that date.

PLEASE PRINT CLEARLY

Name _____ Home phone _____

Address _____ Date of Birth ____/____/____

School _____ Grade _____ Email _____

Do you have any medical conditions, allergies or dietary concerns the Youth Leaders should know about? _____

Mother's Name _____ Home Phone _____

Home address _____ Work Phone _____

(If different) _____ Cell Phone _____

Father's Name _____ Home Phone _____

Home address _____ Work Phone _____

(If different) _____ Cell Phone _____

Authorization for Treatment:

I request and authorize the Youth Advisors of Shenkel United Church of Christ, and area hospitals, medical staff personnel, agents and employees, to provide all medical care including but not limited to hospital test, such as pathology, radiology and anesthesia, surgery, and prescriptive drugs advisable for the health of my child. I acknowledge that no representations warranties, or guarantees as to result or cures will be made.

I give ___ I do **NOT** give ___ my permission to take acetaminophen (Tylenol) or ibuprofen (Advil) for pain relief for headaches, menstrual cramps, and minor aches and pains. Any other medication, both prescription and over-the-counter, must be brought by your child to the event. Please give him/her a signed note giving your permission to take this medication (name each one) and relevant instructions. In the event I cannot be reached and emergency hospital care/treatment is needed, I understand my child will be taken to the nearest hospital and given emergency care.

Signature of Parent/Guardian _____ Date _____

Student's Physician _____ Phone _____

Student's Dentist/Orthodontist _____ Phone _____

Date of last tetanus shot _____

Your Insurance/major medical company _____

Group or personal policy # _____ Policyholder's ID # _____

Please attach photocopies of the front and back of your insurance card.

PLEASE NOTIFY SHENKEL UCC IF THERE ARE ANY CHANGES TO THIS FORM DURING THE PROGRAM YEAR. THANK YOU.

**AUTHORIZATION TO DISCLOSE HEALTH
INFORMATION TO A THIRD PARTY**

This authorization gives any and all Health Care Providers permission to disclose health information about your child/minor to the named representative of Shenkel United Church of Christ **August 1, 2009 through September 30, 2010.**

This authorization may be revoked at any time by submitting a written revocation to Shenkel United Church of Christ.

Name of minor/patient (please print)

In the event of an emergency, every effort will be made to contact the parent or guardian. I understand that if I cannot be contacted, the Church staff will obtain emergency care and I will be responsible for the payment of the expenses that are incurred.

Signature of Parent/Guardian

Date

Please sign under either YES or NO below:

YES

1. I, _____ (Parent/Guardian) hereby authorize any and all Health Care Providers to disclose the specific health information described in #2 below for the purposes, the duration of time, and to the parties described below.
2. Description of the specific information to be disclosed: room/location of patient, laboratory results, billing information, diagnosis, and treatment.
3. Duration of time that the authorization to disclose exists: from **8/1/09 to 9/30/10.**
4. Recipients of the information: Rev. Bonnie Moore, Shenkel United Church of Christ youth group advisors or their designees.

Signature of Parent/Guardian

Date

NO

I, _____ (Parent/Guardian) choose **NOT** to sign this authorization granting permission for the above stated individuals to act in my place. I will personally pick up and be responsible for the medical treatment of my child as it may become required.

Signature of Parent/ Guardian

Date