

NEW LIFE LUTHERAN CHURCH

4380 Wakonda Dr., Norwalk, IA 50211

YOUTH MEDICAL RELEASE AND CONSENT FORM

(Each participant must complete this form)

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ ZIP: _____ PHONE: _____

NAME OF PARENT(S)/GUARDIAN(S): _____

NAME OF PHYSICIAN: _____ PHONE: _____

NAME OF DENTIST: _____ PHONE: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____ PHONE: _____

(Please photocopy insurance cards and include with this form)

CURRENT MEDICATIONS TAKEN BY PARTICIPANT (LIST NAME AND DOSAGE):

HEALTH HISTORY: (MAJOR ILLNESSES, LAST TETANUS SHOT, ALLERGIES, ETC.):

FATHER EMPLOYED AT: _____ PHONE: _____

MOTHER EMPLOYED AT: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____

RELATIONSHIP TO PARTICIPANT: _____

Dear Parent or Guardian:

This form will be presented to the attending physician if your child needs medical treatment in your absence. This will prevent delay of treatment with your signature and photocopied insurance card.

Parent/Guardian (name) _____ "I hereby authorize the treatment, administration of anesthesia and surgical treatment for my child (name) _____ in the event of a medical emergency occurring during my absence or when hospital or medical personnel cannot contact me. This authorization extends to all medical facilities and personnel regardless of setting, in or out of a medical facility, in the treatment of my minor child."

Signature of Parent/Guardian _____ Date _____

Signature of Witness _____ Date _____