VHUMC Student Ministry – Student

MEDICAL INFORMATION

Valid June 1, 2019 to May 31, 2020

Student's Full Name:_____

Goes By:_____ Gender:_____ DOB:_____ Age: _____

Address_____City / Zip_____

Home Phone: _____ Cell Phone: _____ Grade _____

Name of Father or male guardian: _____

Email Address: _____ Occupation:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Name of Mother or female guardian: _____

Email Address: _____ Occupation:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Emergency Contact other than parent/guardian:

Name:_____ Relationship to student: _____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Physician's Name:_____ Phone:_____

HEALTH HISTORY (check all that apply)

Frequent ear infections _____	Chicken pox _____	**SUBJECT TO:** Sleep Walking: _____
Frequent Colds / Sore Throats _____	Measles _____	Fainting _____ Bedwetting_____
Sinusitis / Bronchitis _____	Mumps _____	Constipation_____ Other_____
Strep Throat _____	German Measles _____	**ALLERGIES**:
Mononucleosis _____	Whooping Cough _____	Aspirin _____
Heart Defect / Disease _____	Tuberculosis _____	Peanuts/Nuts_____
Epilepsy / Convulsions _____	Polio _____	Food _____
Bleeding / Clotting Disorders _____	Diabetes _____	Insect Stings _____
Hypertension _____	Asthma _____	Poison Ivy/Oak/Sumac _____
Stomach Problems _____	Arthritis _____	Hay Fever, etc. _____

Others Not Listed or Details of Above: _____

_____

Are immunizations up to date? _____ If no, please explain _____

Date of last Tetanus Shot _____ Date of last TB skin test _____

Any activity limitations? _____ Do you wear contacts? _____

Any specific activities to be encouraged? _____

Any specific activities to be restricted? _____

List any medications or drugs taken regularly _____

Any special medical or dietary regime to be continued? _____

Suggestions for Chaperones or Church Leaders _____

_____

SEE REVERSE

VHUMC Student Ministry - Student

MEDICAL RELEASE & INSURANCE INFORMATION

Valid June 1, 2019 to May 31, 2020

Name of Student:_____

Insurance issued in the name of:_____Is coverage for dependents?:_____

Medical/Health Insurance Co. Name: _____

Policy :_____ Group #:_____ Preauthorization Phone#: _____

I certify that the above-named youth is my child or my legal ward and resides with me. In the event he/she becomes ill, is injured, or for any reason requires medical treatment while attending a Vestavia Hills United Methodist Church function or activity, I do hereby consent to any and all medical or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physician or health care provider selected by agents or officials of the Vestavia Hills United Methodist Church. In the event treatment is called for which a physician or other health care provider refuses to administer without my/our consent, I/we hereby authorize the Staff at Vestavia Hills United Methodist Church or any other representatives of Vestavia Hills United Methodist Church, to give such consent and I further agree to defend, indemnify, and hold any such person harmless from any claims, demands, or suits of any nature arising from the giving of such consent, so long as the treatment is administered by or under the supervision of a licensed physician. I further authorize the release of the listed medical information to medical personnel and/or the health coverage insurance company. I will notify the church if I feel there are any health considerations that would prevent my child's participation in any activity. I also give my permission for leaders to restrict my child from participation in any activities that they have any questions about for health or other reasons.

The intention of this release is to grant authority to administer and perform any and all examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician or other health care professional. I will insure that payment is made for all medical expenses incurred for medical treatment for the above named youth. This payment will be made by myself or by my insurance company providing coverage for the above-named youth.

As the parent (or legal guardian), I the undersigned, certify that my child, named above, has my express permission to participate in all activities, of any nature, sponsored by Vestavia Hills United Methodist Church for the dates listed above. I fully release Vestavia Hills United Methodist Church, its trustees, officers, volunteers, authorized representatives, and staff from all liability of any kind and character from any claim, demand, or cause of action that might be asserted by us or on our behalf against said church, representatives or staff.

Signature of Parent/Guardian: _____ Date _____

Sworn to and subscribed before me on this _____ day of _____ .

NOTARY PUBLIC
State of Alabama, My commission expires: _____

_____
COMMISSIONED NAME OF NOTARY PUBLIC

Personally known_____ or _____Produced Identification (list type)

SEE REVERSE