MISSION STUDENTS

STUDENT RELEASE & MEDICAL FORM

EFFECTIVE DATES Today's Date – December 31, 2021 **CAMPUS ATTENDING** ☐ Lancaster ☐ Myerstown

STUDENT'S CONTACT INFORMATION

☐ Male ☐ Female

Name Last First Middle Birth Date ____ /____ /____

Address _____

City _____ State _____ Zip _____

Email _____

Mobile _____ Home _____

School _____

Grade ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th

PARENT'S / GUARDIAN'S CONTACT INFORMATION

Dad's / Guardian's Name _____ Mobile _____ Work _____

Email _____

Address *(if different than student's)* _____

City _____ State _____ Zip _____

Mom's / Guardian's Name _____ Mobile _____ Work _____

Email _____

Address *(if different than student's)* _____

City _____ State _____ Zip _____

Do both parents have custody? ☐ Yes ☐ No If no, who is the custodial parent/guardian? ☐ Dad ☐ Mom

EMERGENCY CONTACT INFORMATION

Parents will be contacted first. However, in the event that parents can't be reached, we will inform the following people:

Name _____ Relationship to Student _____

Mobile _____ Home _____ Work _____

Name _____ Relationship to Student _____

Mobile _____ Home _____ Work _____

INSURANCE INFORMATION

Medical Insurance Company _____ Office Phone _____

Policy Holder's Name _____ Policy / Group # _____

Primary Care Doctor / Provider _____ Office Phone _____

Dentist _____ Office Phone _____

HEALTH HISTORY

Please check all that apply

- ☐ Seasonal Allergies
- ☐ Heart Defect / Disease
- ☐ Psychiatric Treatment
- ☐ Hypertension
- ☐ Seizures / Convulsions
- ☐ Frequent Ear Infections
- ☐ Blood Disorders
- ☐ Mononucleosis
- ☐ Gastrointestinal Issues

• Most recent _____

• Medications _____

☐ Diabetes
- • Glucose testing? ☐ Yes ☐ No
- • On insulin? ☐ Yes ☐ No

☐ Asthma
- • Use of inhaler? ☐ Yes ☐ No
- • Self-administration? ☐ Yes ☐ No

Other conditions not listed above
Please explain: _____

MEDICATIONS

Please list any medications taken routinely, along with the dosage and frequency.

Medicine 1 _____

Medicine 2 _____

Medicine 3 _____

ALLERGIES

Please be as specific as possible

☐ Insect Stings / Reactions _____

☐ Food Allergies / Reactions _____

☐ Medication Allergies _____

☐ Prescribed EpiPen
- • Can student self-administer EpiPen? ☐ Yes ☐ No

OVER-THE-COUNTER MEDICINES

Do we have your permission to give your student Acetaminophen or Ibuprofen according to the prescribed dosages listed on the bottle if they complain of minor headaches, cramps, or other aches / pains?
☐ Yes ☐ No

OTHER MEDICAL INFORMATION

Basic first aid will be administered as needed, unless noted by the parent. Please explain below if you wish to decline.

Does your student wear: ☐ Glasses ☐ Contact Lenses
Date of last tetanus shot _____

Approximate Height _____ Approximate Weight _____

Please explain if this student's activities should be restricted for any reason _____

PARENTAL CONSENT & WAIVER

I / We the undersigned have legal custody of the student named above, a minor, and have given our consent for him / her to attend events organized by Mission Church (hereinafter the "Church"). I / We understand that there are inherent risks involved in any activity (typical Mission Students activities include, but are not limited to youth group games, gagaball, kickball, other similar activities, and occasional swimming) and participation includes possible exposure to and illness from infectious diseases including but not limited to MRSA, influenza, and COVID-19. While adherence to particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist. I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releasees or others, and assume full responsibility for my / our student's participation. I / we hereby release the Church, its leaders, employees, agents, and volunteer workers from any and all liability for any injury, illness, disability, loss, death, or damage to person or property that may occur during the course of my / our student's transportation to and from the event (if provided by Mission Church) and their involvement in it. In the event that he / she is injured and requires the attention of a medical professional, I / we consent to any reasonable medical treatment as deemed necessary by a licensed physician. This consent form gives permission to seek whatever medical attention is deemed necessary, and releases Mission Church and its staff of any liability against personal losses of named student. Every effort will be made to ensure the safety of your student; however, accidents and injuries may occur even when precautions are taken. In the event treatment is required from a physician and / or hospital personnel designated by the Church, I / we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I / We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by my health insurance provider.

I also agree to place my student in the care of Mission Church's staff and volunteers, understanding that my student is subject to the Church's rules and regulations. I understand that, if my student fails to adhere to any verbal or written rules, the staff and volunteers reserve the right to send my student home and not refund any money that may have been collected for an activity.

I give my permission for any photographs or video taken of my student in conjunction with Mission Church to be used in any highlight presentations, Sunday morning worship services, and / or future promotional materials.

Privacy Policy

Mission Church values your privacy and will not sell, rent, or otherwise give out your personal information (including photographs or videos of your student) for use outside of Mission Church purposes.

Parent / Guardian Signature _____ Date _____