

Fox Chapel Presbyterian Church
384 Fox Chapel Road, Pittsburgh, PA 15238
412-963-8243

Medical Release Form
June 1, 2009 to May 31, 2010

PERSONAL INFORMATION:

Name _____ Home Phone _____
Last First Middle Initial

Home Address _____
Street City Zip

Birth Date _____ Sex: _____ Female _____ Male

Parent(s)/Guardian, if participant is under the age of 18:

Father's Name _____

Address _____
Street City Zip

Phone #'s: Home _____ Work _____ Cell _____

Mother's Name _____

Address (if same leave blank) _____
Street City Zip

Phone #'s: Home _____ Work _____ Cell _____

EMERGENCY: In case of emergency, notify (if parent(s)/guardian is not available):

Name _____ Home Phone _____

Relationship _____ Work Phone _____ Cell Phone _____

Address _____
Street City Zip

HEALTH HISTORY: All participants MUST complete the following.
Please check the allergies the participant may have:

Allergies	Type of reaction
<input type="checkbox"/> Medicines	_____
<input type="checkbox"/> Insect stings	_____
<input type="checkbox"/> Hay Fever	_____
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Foods	_____
<input type="checkbox"/> Others (specify)	_____

Any specific activities to be encouraged limited or avoided:

Current Medication:		
Name	Dosage	When Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Physician:	
Name _____	Phone Number _____

Insurance Information:	
Name of Insurance Company _____	
Policy Number _____	ID Number _____

Parent(s)/Guardian Please read and sign below:

The health history is correct as far as I know. I know and understand that unanticipated events might arise. I give permission for _____ to participate in activities except as noted. I also give permission to authorize personnel to carry out such emergency diagnostic and therapeutic procedures as may be necessary for myself or my child and also permit such treatment procedures to be carried out at, any by the local hospital(s) for myself or my child in the event of an emergency. I understand that any medical expenses will be billed directly to me or my insurance company.

I also give the supervising adult permission to administer minor first-aid procedures.

_____ Date _____
Participant (if 18 or older) / Parent or Guardian Signature

Please Note: I understand this medical information will be kept on file this year and will accompany the participant on all off site activities. If any of the above information changes, it is my responsibility to notify Fox Chapel Presbyterian Church, in writing, of the changes.

_____ Date _____
Participant (if 18 or older) / Parent or Guardian Signature