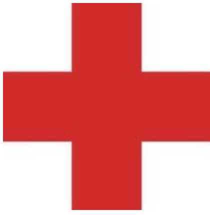

St. Paul's UCC
19th & Lincoln Avenue
Northampton, PA 18067

2021-2022 Medical Release Form

This information will be kept confidential and used only in the event of a medical emergency during an authorized activity sponsored by St. Paul's.

Name of Participant ____ Male _____ Female ______

Address: ____

Birthdate: ____ Age: _____________________

Phone Number: ____

Parent's Name: ____

Address: ____

Phone Number: ____

Emergency Contact Person: ____ Relationship ____________

Address: ____

Day Phone # _______________________________ Evening ___________________________________

If the Emergency Contact Person cannot be contacted, the following person can be called:

Name ____ Relationship _____________

Address ____

Day Phone # _______________________________ Evening ___________________________________

An attempt will be made to reach the emergency contact person, however, in the event that this person cannot be reached and ___________________________________ needs medical treatment while attending this event, I hereby authorize a responsible adult assisting him/her to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care at a licensed hospital which is deemed advisable by, and is rendered under the general or special supervision of any physician and/or surgeon licensed to practice medicine.

continued on back

Family physician ____ Phone number ____________________

Address ____

Date of last Tetanus shot ____

Is there a history of any illness or disability such as diabetes, epilepsy, allergies, asthma, etc.? Are there any dietary restrictions?

If yes, please explain ____

____

____

Is the participant presently taking any medications? If yes, please specify _____________________________

____

____

Have you had any recent medical problems: ie sprains, fractures, or concussions? If yes, please explain ______

____

____

For those under 18 years of age:

Tylenol/Aspirin Permission ….. I hearby give permission to Staff/Designated Adult to give

Administer Tylenol as needed Yes __________ No ___________

Administer Aspirin as needed Yes __________ No ___________

Prescription medication, please designate when and dosage ____________________________

____

Signature of Participant ____

Signature of Parent (if Participant is under 18) ____

Date ____