THIS FORM MUST BE NOTARIZED
Today's Date _____

Name of City _____
Church_____

GIRLS

EMERGENCY MEDICAL RELEASE FORM

Each attendee must turn in this Emergency Medical Release form before she will be permitted to participate in District Girls Ministries event activities. **Please turn in upon arrival,** and pick up before departure for home.
DO NOT SEND THIS FORM TO THE DISTRICT OFFICE

NAME _____ Phone (_____) _____ D.O.B. _____/_____/_____

ADDRESS _____

My child is a **swimmer** / **non-swimmer** and **has** / **does not have** my permission to swim (_____).
(Circle one) (Circle one) (*Date*)

IF PARENT/GUARDIAN CANNOT BE CONTACTED, PLEASE NOTIFY:

Name _____ Name _____

Phone (H) _____ (C) _____ Phone (H) _____ (C) _____

Minor's Physician _____ Phone _____

Medical/Hospital Insurance Carrier _____ Policy/Group # _____

Are you a member of HMO? _____ Policy # _____

Date of last examination _____ Is activity restricted? _____ No _____ Yes

Explain: _____

IMMUNIZATIONS: Are school shot records current? (circle one) YES NO

CHRONIC/RECURRING CONDITIONS: (Please check any that apply)

_____ Seizure Disorders _____ Diabetes _____ Fainting _____ Headaches

_____ Heart Disease _____ Kidney Disease _____ Nosebleeds _____ Asthma / Respiratory problems

Other: _____

ALLERGIES: **(Check *all* that apply; be specific on any types of reaction!) If no allergies, circle NONE**

_____ Animal _____ _____ Plants_____

_____ Food_____ _____ Pollen _____

_____ Insect Bites _____ _____ Medicines / drugs _____

_____ Latex_____ _____ Nuts_____

_____ Other _____

May be given OTC medicine as needed? ie: Tylenol, Motrin

_____Yes _____No

Has begun menstruation? _____ Yes _____No **Is informed about Menstruation?** _____ Yes _____ No

Current medications: _____ **Is in child's possession?** _____ Yes _____ No

Child wears: _____ Contact Lenses _____Glasses _____Dental appliance _____ Other

Does your child ever sleepwalk? _____ Yes _____ No

IN CASE OF EMERGENCY I CAN BE REACHED AT _____
(Area code and Phone number)

Parent/Guardian Statement: I authorize the adult in charge to consent to medical treatment if I cannot be contacted. I understand that every effort will be made to contact me before such action is taken. I assume financial responsibility for emergency care if such care is not covered by church's insurance.

_____ _____
PRINT MOTHER'S NAME PRINT FATHER'S NAME

_____ _____
Mother's Signature Father's Signature

_____ _____
Address / City / Zip Address / City / Zip

(_____) _____ (_____) _____
Phone Phone

Subscribed and sworn before me this _____ day of _____ 20 _____

_____
Notary