

Saint Michael and All Angels Episcopal Children and Family Ministry
The Edge Health Information and Medical Release Form
2007-2008 School Year

Child Name _____
Last First Middle Preferred Name

Sex _____ Date of Birth _____ Age _____

School attending 2007-2008 _____ Grade _____

Father/Guardian

Mother/Guardian

Full Name _____

Full Name _____

Preferred Name _____

Preferred Name _____

Home Address _____

Home Address _____

Zip Code _____

Zip Code _____

Home Phone _____

Home Phone _____

Work Phone _____

Work Phone _____

Cell Phone _____

Cell Phone _____

(NOTE: Please star the phone number at which it is best to reach each parent in case of emergency)

E-mail address _____

E-mail address _____

Parent Status (check all that apply)

____ Married ____ Divorced ____ Mother Remarried ____ Mother Deceased ____ Single Mother

____ Separated ____ Father Remarried ____ Father Deceased ____ Single Father

Custody (choose only one)

____ Both Parents ____ Mother ____ Father ____ Joint Custody

____ Other Relative(s) ____ Guardian ____ Other-Specify _____

Child lives with: _____

If Parents live at separate addresses, where should The Edge mailings be sent?

____ Mother's address ____ Father's address ____ Both addresses

Health Information (will be kept locked in a confidential file unless needed during an emergency)

Health History (check, giving appropriate dates):

____ Asthma	____ Constipation	____ Diabetes
____ ADD	____ Serious Ivy, Oak, or Sumac poisoning	____ Measles
____ ADHD	____ Epilepsy	____ Mumps
____ Frequent Colds	____ Kidney Trouble	____ Poliomyelitis

Health History Continued

Frequent Sore Throats
 Heart Trouble
 Convulsions
 Eating Disorders
 Frequent Upset Stomachs

Whooping Cough
 Rheumatic Fever
 Tuberculosis
 Fainting
 Operations or Serious Injuries

Sinusitis
 Frequent Ear Infections
 Bronchitis
 Sleep Walking

Specify: _____

Allergic Reactions: Bee Stings Penicillin Other: _____

Does he/she have any dietary allergies or restrictions? Specify: _____

Please provide any additional information on above: _____

Any specific activities to be encouraged or restricted? _____

Routine Medication Information

Medication	Form	Dosage	Time

* I will provide written out instructions for any medications that need to be given while attending any Edge function.

I give my permission for this child to receive Tylenol, aspirin or aspirin substitute. YES NO

I give my permission for this child to receive Benadryl or other over the counter decongestant. YES NO

I give my permission for this child to be given any of the following over the counter medications:

Is there any other health related information Children and Family Ministries should have (please describe): _____

Illness & Accident Information

Authorized Physician
Name _____

Address _____

Health Insurance
Company _____

Policy/Group Number _____

Phone Number _____

Phone Number _____

Illness & Accident Information Continued

Emergency Contacts (other than parents, in case we can't reach you)

Name _____

Name _____

Phone (s) _____

Phone(s) _____

Relationship _____

Relationship _____

Name _____

Name _____

Phone(s) _____

Phone(s) _____

Relationship _____

Relationship _____

Authorization for Medical Treatment for _____
Child's Name

Please check every line either "yes" or "no". This page MUST be signed.

___ YES ___ NO 1. I authorize minor first aid treatment to be given.

___ YES ___ NO 2. If medical attention is needed and the church is unable to locate me, I hereby authorize the physician set forth above or any person designated by the physician or any emergency care provider to perform such examinations, procedures, and treatment as may be advisable.

___ YES ___ NO 3. I consent to the administration of anesthesia to be applied by or under the direction of the physician listed above or any person designated by the physician or an emergency care provider.

___ YES ___ NO 4. I authorize emergency transportation.

___ YES ___ NO 5. I agree to assume full responsibility for any cost or expense incurred as a result of any medical or emergency care provided for my child.

Parent/Guardian Authorization & Release

This health history is correct to the best of my knowledge, and my child (as named above) has permission to engage in all Edge activities sponsored by Saint Michael and All Angels Episcopal Church except as noted on this form. In the event I cannot be reached in an emergency, I hereby give my authorization for the medical care for which I have marked "yes" above. Further, I release Saint Michael and All Angels Episcopal Church, its volunteers, clergy, vestry, and employees from any and all liability, claims and demands of whatever kind or nature, either in law or in equity, which arise out of my child's (as named above) participation in events, activities or outings relating to or sponsored by The Edge Program.

Signature _____ **Date** _____