Student Information and Health History

Name of Student:

Sex: Date of Birth: Grade:

School:

Parent / Guardian:

Address (Please Include City and Zip Code):

Phone (Daytime): Phone (Work or Other): Phone (Cell):

Email:

Med. Allergies (Prescription or Non-Prescription) / Food Allergies:

Physician: Phone:

Present Medications (and Instructions) / Medical Conditions:

Date of Last Tetanus Booster (If Known): Please attach a copy of your insurance card.

Check if participant is subject to any of the following:

- ☐ Headaches
- ☐ Seizures/Convulsions
- ☐ Fainting
- ☐ Sinusitis
- ☐ Asthma
- ☐ Cramps
- ☐ Bronchitis
- ☐ Ear Infection
- ☐ Allergies

Check medications that a participant may receive if deemed necessary and administered by an adult sponsor of Gulfview Grace Brethren Church (Reignite Youth Conference):

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen
- ☐ Antacids
- ☐ Cold Medications
- ☐ Cough Medications
- ☐ Allergy Medications

I, the undersigned parent/guardian of:____
do hereby authorize Gulfview Grace Brethren Church (Reignite Youth Conference) or any responsible adult person bearing this written authorization, into whose said care the above mentioned minor child has been entrusted, to obtain proper medical care from a licensed medical or dental facility. The medical care is to include, but not to be limited to, any x-ray exam, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor under the general or special supervision and upon the advice of a licensed physician and surgeon, and to consent to an x-ray exam, anesthetic, dental or surgical diagnosis or treatment and hospital care to said minor by a dentist. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of said adult person to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician or dentist in the exercise of his better judgment may deem advisable. This authorization shall include transportation to receive the medical or dental care. The authorization will remain in effect during the above stated dates while the minor above is en route to or from or involved or participating in any program or activity authorized by Gulfview Grace Brethren Church (Reignite Youth Conference). It is my desire that my child/ward participate in the activities of Gulfview Grace Brethren Church (Reignite Youth Conference). In the event of injury to my child/ward I agree that I and my health care insurer, shall be financially responsible for any medical treatment required for my child/ward as a result of an injury suffered during his/her participation in the above or related activities. I am aware that these activities may involve some hazards. I have considered these risks and I still wish my child/ward to participate. Furthermore, I agree not to bring legal action against Gulfview Grace Brethren Church (Reignite Youth Conference) as a result of any injuries suffered in the course of his/her participation.

Parent/Guardian Signature:____

Parent/Guardian Name:____

Date:___________________________________Relationship:___________________________________

Medical Insurance Co.:____

Address:____

Pre-Certification Phone #:____