



**EMERGENCY MEDICAL RELEASE FORM
CALVARY CHAPEL LAKE ARROWHEAD
101 Grandview PO Box 1210 Twin Peaks, Ca 92391**

Required form for ALL CLAY events & need to be completely filled out!
Current form is good from **July 01.08 - June 30.09**

Youth Name (First, Last) _____

PO Box _____ City _____ Zip _____

Street Address _____

City _____ Zip _____

Phone # _____ : _____ : _____ Birthday ____/____/____

School _____

Grade _____ Email _____

Dad's Name (First, Last) _____

Mom's Name (First, Last) _____

Medical Group Name _____

Policy # _____ Name Insured _____

Family Physician _____

Office Phone # _____

Relative, neighbor, or friend (other than parents/legal guardians listed above) to be contacted in an emergency:

Name (First, Last) _____ Relationship _____

Phone # _____ : _____ : _____ Cell/Work # _____ : _____ : _____

(Secondary Contact)

Name (First, Last) _____ Relationship _____

Phone # _____ : _____ : _____ Cell/Work # _____ : _____ : _____

HEALTH HISTORY (check giving approximate dates):

frequent ear infections _____

heart defect/disease _____

convulsions _____ diabetes _____

bleeding/clotting disorder _____

bed wetting _____ sleep walking _____

operation or serious injury _____

ALLERGIES

hay fever _____ insect stings _____

penicillin _____

other allergies (list) _____

(Please turn over)

DISEASES

chicken pox _____ measles _____
german measles _____ mumps _____
asthma _____ other _____

1. To your knowledge, has your child been exposed to any communicable diseases (TB, Malaria, etc.) recently? Yes _____ No _____

If yes, which one(s)? _____

2. Do you know of any health factor(s) that makes it advisable for your child to follow a limited program of physical activity? Yes _____ No _____

Please explain: _____

RANDOM DATA

Shirt Size _____ Sweatshirt Size _____ Shoe Size _____

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF MINOR CHILD

In the event of a serious accident or illness that may befall your child, the leadership of Calvary Chapel Lake Arrowhead will make every effort to contact you at home or place of business and comply with your instructions.

If you cannot be located, Calvary Chapel Lake Arrowhead is authorized to:

1. Contact the family physician or alternate names above and follow their instructions.

2. Transport the above named child to a local hospital for treatment by the Emergency Room physician on duty. .

3. The undersigned hereby authorizes the physicians named above to give consent for any procedure or hospital care deemed advisable by said doctor.

In the event the doctor is not available Calvary Chapel's leadership is authorized to give the necessary consent for any treatment, care, diagnosis or examination of the above named person.

4. In the case of an emergency, I authorize the child named above to be treated at the Hospital and/or Emergency Room he or she is taken to in an emergency situation.

I hereby release Calvary Chapel Lake Arrowhead, its employees, and agents from all liability for any injury, death or damage while participating in or being transported to and from fellowship activity.

(PARENT OR LEGAL GUARDIAN ONLY)

Print Name: _____

Signature: _____

Date: _____

(STUDENT)

Signature: _____

Date: _____