



MEDICAL FORM

Complete one form per registrant; please print clearly

Participant's Last Name _____ Participant's First Name _____

Participant's Date of Birth (MM/DD/YYYY) _____ Participant's Social Security # _____

Parent(s)/Guardian _____

Home Phone _____ Cell Phone _____ Work Phone _____ E-Mail _____

Home Address _____ City _____ State _____ Zip _____

MEDICAL TREATMENT PERMISSION & RELEASE

I desire my child to participate in the Bryn Mawr Presbyterian activity described herein ("the Program"). I understand that there are hazards and risks, as well as benefits, associated with my child's participation in the Program. In consideration of the benefits of my child's participation in the Program, I, on behalf of myself, my child, my or their heirs, executors, administrators, agents, assigns, and other personal representatives, irrevocably and unconditionally remise, release, settle, compromise, and forever discharge any and all manner of suits, actions, causes of action, damages and claims, known and unknown, that I or my child, have or may have against Bryn Mawr Presbyterian Church and/or its trustees, officers, employees, agents assigns, contractors, or volunteers arising from or connected with my child's participation in the Program, including the securing of medical treatment for my child curing my child's participation in the Program.

I give my permission to Bryn Mawr Presbyterian Church, its employees, agents, assigns, contractors, or volunteer supervisors to secure medical treatment for my child in the event that such treatment is needed during my child's participation in the Program or related activities. I agree to assume financial responsibility for the cost of such treatment.

The laws of the Commonwealth of Pennsylvania shall apply to this Medical Treatment Permission & Release. If any of the provisions, terms, clauses, or waivers or releases of claims or rights contained herein are declared illegal, unenforceable, or ineffective in a legal or other forum or proceeding, such provisions, terms, clauses or waivers and releases shall be deemed servable, and all other provisions, terms, clauses and waivers and releases of claims and rights contained herein shall remain valid and binding.

I sign this document with the intent to be legally bound by it. I am an adult, competent to sign this document. I am signing this document voluntarily. I have read it and I understand its contents.

Parent(s)/Guardian Name (please print) _____

Parent(s)/Guardian Name (signature) _____ Date _____

EMERGENCY CONTACT INFORMATION

Parent(s)/Guardian Name _____

Home Phone _____ Cell Phone _____ Work Phone _____ E-Mail _____

Contact Name _____ Relation _____

Home Phone _____ Cell Phone _____ Work Phone _____

Contact Name _____ Relation _____

Home Phone _____ Cell Phone _____ Work Phone _____

MEDICAL FORM

INSURANCE INFORMATION

Name of Insurance Policy Holder _____

Carrier _____ Policy # _____ Group # _____

PHYSICIAN INFORMATION

Physician's Name/Practice _____

Phone _____ FAX _____

Office Location _____ City _____ State _____ Zip _____

MEDICAL CONDITIONS

PLEASE CHECK ALL THAT APPLY

- | | | |
|--|--|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Dizziness/Fainting/Blackouts | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Chronic Bed Wetting | <input type="checkbox"/> (If applicable) Has your daughter had her first menstrual period? | |

ALLERGIES (Check)

REACTION (Describe)

TREATMENT (Medication/Dosage)

- | | | |
|---|-------|-------|
| <input type="checkbox"/> Aspirin | _____ | _____ |
| <input type="checkbox"/> Food Allergies | _____ | _____ |
| <input type="checkbox"/> Insect Stings | _____ | _____ |
| <input type="checkbox"/> Latex | _____ | _____ |
| <input type="checkbox"/> Other Medication | _____ | _____ |
| <input type="checkbox"/> Other Medication | _____ | _____ |
| <input type="checkbox"/> Penicillin | _____ | _____ |
| <input type="checkbox"/> Sulfa | _____ | _____ |
| <input type="checkbox"/> Tetracycline | _____ | _____ |

SPECIAL MEDICATION: This information will be kept confidential. Please specify all medication(s) your child/student is currently taking, the dosage and how often it should be administered. Please note that we will not administer any medication during program hours unless we have written permission from you and your child/student's physician. Please be sure to supply any medication necessary for your child. All medications should be clearly labeled with name and instructions and placed in a sealed, clear plastic bag. _____

PLEASE NOTE: We are unable to dispense any medication without documentation from your child's doctor. This includes: aspirin, acetaminophen, ibuprofen, Benadryl, Epi-Pen.