MEDICAL RELEASE FORM

MINOR CHILD

EFFECTIVE FOR ALL TRIPS AND/OR FUNCTIONS WITH THE SUNSET CHURCH OF CHRIST FOR THE YEAR OF 2026 .

NAME: _____

ADDRESS: _____ BIRTHDATE: _____

PHONE NUMBER: _____ PARENT or GUARDIAN'S NAME: _____

MEDICAL INFORMATION

PHYSICIAN'S NAME and TELEPHONE #	DRUG ALLERGIES	CURRENT MEDICATIONS

LIST ALL PERTINENT MEDICAL PROBLEMS: _____

*** I give permission to dispense over the counter medications to my child: ☐ Yes ☐ No**

IN CASE OF EMERGENCY, CONTACT:

NAME: _____ CELL PHONE: ( ) _____

HOME PHONE: ( ) _____ BUSINESS PHONE: ( ) _____

2ND CONTACT:

NAME: _____ CELL PHONE: ( ) _____

HOME PHONE: ( ) _____ BUSINESS PHONE: ( ) _____

MEDICAL INSURANCE INFORMATION:

POLICY HOLDER: _____ GROUP #/ POLICY # _____

INSURANCE CO.: _____

INSURANCE PHONE: ( ) _____

SUNSET CHURCH OF CHRIST MEDICAL INSURANCE: Accidental medical benefits are provided for members and guests while involved in any church sponsored event. The limit per person is $5,000.00. Organized sporting events and automotive related injuries are excluded. Automotive related injuries are provided for under the vehicle policy with a limit of $2,500.00 per person. There is no coverage under these policies for sickness whether sudden or not, unless caused by a covered accident.

MEDICAL RELEASE:

I understand that in the event medical treatment is required for the above-named MINOR, that every effort will be made to contact me (us). However, if I cannot be reached, I give my permission to the staff or sponsor of the Sunset Church of Christ to secure the services of a licensed physician to provide the care necessary, including anesthesia, for my child's well-being.

SIGNED: _____ DATE: _____

(Parent or Guardian)

Medical information for: _____ Age of child: _____

(Name of child)

Information provided by: _____

(Name of person completing form)

Please indicate if your child has ever been treated for the following conditions:

	YES	NO	Under Current Treatment?	Past Treatment? (Indicate Dates)	List Current Medications:
ADD or ADHD?	☐	☐	☐		
Anxiety?	☐	☐	☐		
Asthma?	☐	☐	☐		
Allergies?	☐	☐	☐		
Bleeding Disorders?	☐	☐	☐		
Broken Bones? (Please indicate)	☐	☐	☐		
Depression?	☐	☐	☐		
Diabetes?	☐	☐	☐		
Epilepsy?	☐	☐	☐		
Fainting (unexplained)?	☐	☐	☐		
GERD?	☐	☐	☐		
Head Injury?	☐	☐	☐		
Heart Problems? (Please indicate)	☐	☐	☐		
Hypertension?	☐	☐	☐		
Hypotension?	☐	☐	☐		
Intestinal Problems?	☐	☐	☐		
Psychiatric Problems?	☐	☐	☐		
Seizures (of any kind)?	☐	☐	☐		

Other:

_____

_____

COMMENTS OR DIRECTIONS FOR CARE:

_____

_____

_____

_____

_____

Signed: _____ Date: _____

(Parent must sign for a minor)