

Health History Form-Faith Christian Fellowship

This form is to be completed by parent/guardian. All information will be kept confidential and used only for the welfare of the participant.

Name _____ Date of Birth _____

Sex: _____ School: _____ Grade _____

Parent(s) Name _____

Address: _____

Phone (Daytime) _____ Phone (Cell) _____

Med. Allergies (Prescription or Non Prescription) _____

Bee/Wasps Sting Allergy? Yes No Prescribed Treatment: _____

Physician: _____ Phone # _____

Present Medical Condition _____

Present Medications and Instructions _____

Date of Last Tetanus Shot: _____

Check if Participant is Subject to:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Home Sickness
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Fainting
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Sleep Walking	<input type="checkbox"/> Cramps

Check medications that student may receive if deemed necessary and administered by an Adult Youth Staff Worker of Faith Christian Fellowship.

<input type="checkbox"/> Antacids	<input type="checkbox"/> Acetaminophen(Tylenol)	<input type="checkbox"/> Ibuprofen
<input type="checkbox"/> Cold Medications	<input type="checkbox"/> Cough Medications	<input type="checkbox"/> Laxatives
<input type="checkbox"/> Diarrhea Medications		

*All student medications need to be marked and put in Ziploc bags or medication containers for each trip/activity along with instructions. There should be enough for the duration of the trip/activity.

Parent Signature _____ Date _____

Medical Authorization Form- Faith Christian Fellowship

16726 Lappans Rd.
Williamsport, MD 21795

I, the undersigned parent/guardian of _____ do hereby authorize the adult sponsor of Faith Christian Fellowship or any responsible adult person bearing this written authorization, into who's said care the above mentioned minor child has been entrusted, to obtain proper medical care from a licensed medical or dental doctor of facility. The medical care is to include, but not 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 physician and surgeon licensed under the provisions of the State Medical Board of Maryland , and to consent to an x-ray exam, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by 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 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 stated dates of **June 1, 2015-May, 31, 2016** while the minor is en route to or from or involved or participating in any program or activity authorized by Faith Christian Fellowship, unless revoked by the undersigned in writing and delivered to the agent of Faith Christian Fellowship.

Release of Faith Christian Fellowship of liability for injuries to minor and agreement that health care insurance of parent/guardian shall be primarily responsible for medical bills.

As the parent/guardian of _____, it is my desire that my child/ward participate in the activities of Faith Christian Fellowship.

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 by 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 Faith Christian Fellowship as a result of any injuries suffered in the course of his/her participation.

In the event a dispute arises between myself and Faith Christian Fellowship concerning injuries to my child/ward, then I agree that the disputes shall be resolved by a Christian Arbitrator acceptable to both sides. The cost of the Arbitrator is to be shared equally by the parties. All applicable statutes of limitation shall apply and arbitration must be requested within the appropriate period in order to reserve a right to recovery.

Parent/Guardian Signature _____ Relationship _____

Student Social Security Number _____

Medical Insurance Company _____

Address _____

Pre-Certified Phone Number _____

Group or ID # _____ Date Signed _____