

Faith EPC
Youth Medical Form and Consent for Trip
(Please print)

Youth Name: _____ Nickname: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Age: _____ DOB: _____

Health Problems: _____
Daily Medicines: _____
Medicine Allergies: _____
Food Allergies: _____ Bee Sting or Other Allergies: _____ Last Tetanus Shot: _____

Does the student have any the following: (Please circle Yes or No)

Diabetes: Yes No Asthma: Yes No Seizures: Yes No Heart Problems: Yes No Insulin: Yes No

Epi-Kit: Yes No Inhalers: Yes No Neb Machine: Yes No

(Note: If the student ever needs an Inhaler, Neb Machine, Epi-Kit or Glucose Monitoring kit, it **MUST** be brought on this trip)

Parent/Guardian Name: _____
Home #: (____) _____ Work #: _____ Pager/Cell #: _____

Parent/Guardian Name: _____
Home #: (____) _____ Work #: _____ Pager/Cell #: _____

Other Emergency Contact Name: _____ Phone: (____) _____

Health Insurance: _____ Policy Number: _____

Doctor's Name: _____ Doctor's Phone: (____) _____

My Child _____ has my permission to attend the Faith EPC Youth Missions trip to the Appalachian Impact Project in Salt Lick, KY from July 23-July 30 2015. I hereby release Faith EPC from all liability should any injury occur on this trip. **Sign:** _____

I give my permission for the Adult Chaperones to administer minor first aid to my child should the need arise. This may include the use of over-the-counter medicines, including: Tylenol or Advil for minor fever/aches/pains; Sudafed for congestion; Benadryl for allergies/rash; Robitussin DM and/or cough drops for coughs; Dramamine for motion sickness or nausea; Visine eye drops for eye redness/irritation; Imodium for diarrhea. I have crossed out any of the medicines that I do not want given to my child. **Sign:** _____

I also give my permission for the Adult Chaperones to use their judgment should my child need urgent medical care. I expect the Adult Chaperones to attempt to contact me before my child is taken to an Urgent Care Facility or Emergency Department, unless there is a life threatening situation, then I expect to be contacted as soon as possible. I hereby authorize the Adult Chaperone to sign for my child's medical treatment should the need arise. I understand that I am ultimately responsible for all medical expenses incurred.

Sign: _____

I am sending my child's prescription medicines (if any) for the Adult Chaperone to administer to my child. I am also sending non-prescription medicines (if any) that my child may need. I am sending all medicines in their original containers that are clearly labeled with the child's name, and how often the medicine is to be given. All medicine containers are in a Ziplock bag that is labeled with my child's name. I acknowledge that all medicines are to be in the care of an Adult Chaperone for dispensing to my child. **Sign:** _____

I agree with the above, and hereby give my consent for this trip.

Parent/Guardian Signature for above: _____ **Date:** _____

For office use only – Reviewed by: _____