United Church of Chapel Hill
1321 Martin Luther King, Jr. Blvd.
Chapel Hill, NC 27514
(919) 942-3540

UCCH Youth Medical and Liability Release Form

(Please Print in Ink) **Date** ___________________

Youth Name____ **Age**_____ **Birthdate** ______________

Grade in School________ **Male** __ **Female** __ **Youth E-mail**_______________________________________

Address______________________________________ **City**____________________ **State**______ **Zip**________

Home Phone_____________________ **Youth Cell Phone**_____________________ **Other** __________________

Medical Insurance Company _____________________________________ **Tel. # of Insur. Co.** ________________

Policy Holder _______________________________ **Policy #** ______________________ **Group #** ______________

Parent/Guardian Name ___________________________ **Ph. H**____________**W**____________ **C**______________

Parent/Guardian Name ___________________________ **Ph. H**____________**W**____________ **C**______________

Parent/Guardian Name ___________________________ **Ph. H**____________**W**____________ **C**______________

Parent/Guardian Name ___________________________ **Ph. H**____________**W**____________ **C**______________

Emergency Contact ________________________________ **Ph. H**_____________**W**____________**C**_____________

Physician: ____ **Office Phone:** ___________________________

Dentist: ____ **Office Phone:** ___________________________

MEDICAL HISTORY: The following information must be completed by the parent/guardian. Please describe any physical or psychological conditions and any actions required. Please keep a copy of the completed form for your records. If there are any changes to this medical history or insurance, please update the church records immediately.

General Questions (please explain "yes" answers in the space provided beside the question, in the space below, or if necessary, add another page with details).

Has / does the participants….. (please **circle the correct answer**)

1. Had any recent injury, illness, or infectious disease? Yes No ______________________________
2. Have a chronic or recurring illness/condition? Yes No ______________________________
3. Ever been hospitalized? Yes No ______________________________
4. Ever had surgery? Yes No ______________________________
5. Have frequent headaches? Yes No ______________________________
6. Ever had a head injury? Yes No ______________________________
7. Ever been knocked unconscious? Yes No ______________________________
8. Wear glasses, contacts, or protective eyewear? Yes No ______________________________
9. Ever had frequent ear infection? Yes No ______________________________
10. Ever passed out during or after exercise? Yes No ______________________________
11. Ever been dizzy during or after exercise? Yes No ______________________________
12. Ever had seizures? Yes No ______________________________
13. Ever had chest pain during or after exercise? Yes No ______________________________
14. Ever had high blood pressure? Yes No ______________________________

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15. Ever been diagnosed with a heart murmur? Yes No ______________________________
16. Ever had back problems? Yes No ______________________________
17. Ever had problems with joints (e.g. knees, ankles)? Yes No ______________________________
18. Have any skin problems (e.g. itching, rash, acne)? Yes No ______________________________
19. Have diabetes? Yes No ______________________________
20. Have asthma? Yes No ______________________________
21. Had mononucleosis in the past 12 months Yes No ______________________________
22. Had problems with diarrhea/constipation? Yes No ______________________________
23. Had problems with sleepwalking? Yes No ______________________________
24. If female, have abnormal menstrual history? Yes No ______________________________
25. Have a history of enuresis (bed-wetting)? Yes No ______________________________
26. Ever had an eating disorder? Yes No ______________________________
27. Ever had emotional difficulties for which professional Help was sought? Yes No ______________________________
28. Have any known allergies? Yes No ______________________________
29. Ever tried to harm themselves? Yes No ______________________________

Other or additional comments:

____
____
____
____
____

1. For your child's safety and our knowledge, is your youth a: ___good swimmer ___fair swimmer ___non-swimmer

2. Does your child have allergies to?
   ___medications ___hay fever ___foods ___insect bites ___poison ivy

   Please describe:

3. Does your child suffer from, or has he/she ever experienced, or is he/she being treated currently for:
   ___asthma ___epilepsy/seizure disorder ___heart trouble ___diabetes

   ___frequent upset stomach ___physical challenges other: ________________________

   Please describe:

4. Date of last tetanus shot: ______________________________

5. Please list and explain any major illnesses or hospitalizations the child has experienced during the last year:

6. Please list and explain any minor illnesses or hospitalizations the child has experienced during the last year:

7. Is the child currently under the care of a physician for any condition?
   If so, what is the condition?

   …and what is the treatment?

8. Anything else the church staff and chaperones should know?

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Restrictions – Please indicate any restrictions or limitations your child has for certain activities.

Medications (please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Send enough medication for the duration of the trip and send it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, the frequency of administration. Please indicate if your child needs to be **discretely** reminded to take their medication. ____________________________

Are there any medications that need to be administered for your child?
1) Name of Medication _____________ For What Condition? _____________ Dosage ________ Frequency ________
2) Name of Medication _____________ For What Condition? _____________ Dosage ________ Frequency ________
3) Name of Medication _____________ For What Condition? _____________ Dosage ________ Frequency ________
4) Name of Medication _____________ For What Condition? _____________ Dosage ________ Frequency ________

Parent/Guardian Signature
This form (1) gives your permission for your child to ride in church transportation and (2) gives the group leaders' authorization to secure medical aid for your child should it be necessary.

To the best of my knowledge, this health history is correct and complete.
I, ____ consent to allow ---____________________________________
(Parent or Guardian *Signature*) **(Youth's name – please print)**
to be transported from and to United Church of Chapel Hill in church transportation for various youth activities. I hereby authorize any hospital, clinic, physician, doctor, nurse, or technician to furnish my ___________________(relation to minor), named above, any medical care and treatment necessary as a result of injuries sustained and other emergency medical care treatment as the circumstances require while being transported from and back to the church while at the place of destination. I hereby authorize a representative of United Church of Chapel Hill to retain or acquire said medical care and treatment in my behalf if I cannot be reached by telephone or there is not time or opportunity to make such a telephone call. I agree not to hold such a person responsible for any damages arising from the giving of such consent.

This is the ___________day of _________________(month), in the year ________.

Updates: Date__________ Initials ______ Date________ Initials______

Date__________ Initials ______ Date________ Initials______