St. Matthew's

Episcopal Church

YOUTH RELEASE FORM

330 N Hubbards Ln • Louisville, KY

895-3485 www.stmatthewsepiscopallouisville.org

Student Information

Student Name: _____ Age: _____ Grade: _____ Date of Birth: _____

Parent/Guardian Information

Parent/Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Email: _____ Primary Phone: _____

Emergency Contact Information

Please note: The minor's Parent/Guardian will always be contacted first.

Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Email: _____ Primary Phone: _____

Insurance Information

Insurance Company: _____ Name on Card: _____

ID #: _____ Group #:_____Policy #: _____

Name of Primary Physician: _____ Phone: _____

Name of Family Dentist: _____ Phone: _____

Health History

List any dietary restrictions: _____

List any activities your child should be restricted from:

_____

Medical History of Participant:

ADD or ADHD?	__ Yes __ No	Eating Disorders?	__ Yes __ No
***Asthma?	__ Yes __ No	Emotional Problems?	__ Yes __ No
Behavioral Problems?	__ Yes __ No	Glasses or contacts?	__ Yes __ No
Cardiac Problems?	__ Yes __ No	Headaches?	__ Yes __ No
Diabetes?	__ Yes __ No	Seizures?	__ Yes __ No
Developmental Delay/ Mental Disability?	__Yes __ No	Stomach Problems?	__ Yes __ No

***Asthma**: Does your child need an inhaler, and if so, what is the action plan used at school?_____

_____

If you answered "yes" to any of the above questions, please give details and special instructions (like an action plan): _____

Medications

____ My child ***does not*** take prescription medications.

____ My child takes the following prescription medications. Please list **all** medications your child may need to receive while in our care. Include the dosage, time of day/night to be given and the medication's purpose. Medications must be brought in an original, labeled bottle.

Medication Dosage/Time Purpose

_____

_____

_____

Allergy Information

List any known allergies your child has or select "none."

None: _____

Medications: _____

Reactions: _____

Treatment Plan: _____

Food: _____

Reactions: _____

Treatment Plan: _____

Does your child normally carry an Epi Pen? ____ Yes ____ No

If you answered **"yes"** please give details and special instructions (like an action plan):

_____

_____

Parental Agreement

Signing this agreement is necessary for your child to attend.

I hereby certify that all the information contained in this release form is up to date and correct. I give permission for my child to be treated by a physician, nurse, or other person appropriately trained in first aid in case of accident or illness. I give permission for my child to be given the medications I provide and if necessary, over the counter medicines such as cough medicine, antacids, poison ivy ointment, etc.

I understand that every attempt will be made to contact the adults on this form if medical intervention is needed, beginning with the parent/guardian(s). Additionally, I understand that with every activity, there is the inherent possibility of risk, and I do not hold St. Matthew's Episcopal Church, its leaders, employees or volunteers liable for damages, losses, diseases, or injuries incurred by the subject on this form.

I give my permission and consent for the use of photography or video that includes my child's image. I further give my permission and consent that any such photographs may be used by St. Matthew's Episcopal Church to illustrate or promote the church's programs.

Parent/Guardian Signature: _____Date: _____