The Congregational Church of Mansfield

A United Church of Christ Congregation

Please Return To: Congregational Church Office
17 West Street
Mansfield, MA 02048-0322
Questions? 508.339.4793

PARENTAL PERMISSION, MEDICAL RELEASE and INFORMATION FORM

I do hereby grant permission for my son/daughter to participate with the Congregational Church of Mansfield's _____ Retreat from _____ to _____ under the supervision of the advisory team. Should the need arise, I further authorize the event advisory team to take such measures as are deemed necessary or desirable for the welfare of my son/daughter; including, but without limitation, medical and/or surgical treatment. I will pay or reimburse all costs and expenses associated with his/her treatment.

Name of Student: _____

Parent/Guardian: _____

Mailing Address: _____

City/State/Zip: _____

DOB: __/__/__

BLOOD TYPE
(if known)
[_____]

Phone: (__) ___-____ (__) ___-_____ _____@_____.___
home work email

Family Physician: _____ Phone: (____) ____-_____

Medical Ins. Provider: _____

Insurance Provider Address: _____ Phone: (____) ____-_____

Medical Insurance Policy Number: _____

ALLERGIES

Does your child have any **allergies**, especially those related to medications, food, or insects which promote a serious reaction? Circle one: **(YES)** **(NO)** If ***YES***, please give details.

MEDICATIONS

Does your child take any **medications**? Circle one: **(YES)** **(NO)** If ***YES***, please provide the type, dose, and reason for this medication. Also explain if your child will need to take this medication during activities and/or retreats and if he/she will need assistance. In addition, please check the medications on the back that youth leaders will be permitted to administer to your child in the event they are needed.

MEDICAL HISTORY

Does your child have any **medical history** (i.e. surgery, illness, chronic condition, etc.) with which we should be familiar?
Circle one: **(YES)** **(NO)** If ***YES***, please describe. Attach an additional sheet if necessary.

Date of Last Tetanus Shot: ___/___/___

SWIMMING ABILITY *(we do not have access to swimming on this retreat so this is non-applicable)*

Does your child swim? Circle one: **(YES)** **(NO)**

If ***YES***, what is her/his level of ability? Beginner - Intermediate - Strong Swimmer - Jr. Lifesaving - Sr. Lifesaving

RESTRICTIONS: Are there any dietary or physical restrictions?

MEDICATION ADMINISTRATION

We always bring a first aid kit that includes various over-the-counter medications. It will be the student's primary responsibility to ask for either "Over the Counter" medication or any "Prescription" medication that he/she brings with them at the proper times. Please check off the medications listed to the right that you grant permission to be administered by an advisory team member should it be needed.

Please use this space below to list any additional information that you believe would be helpful to our advisory team.

Please check the medications we have permission to administer.

- ❑ Tylenol
- ❑ Ibuprofen
- ❑ Benadryl
- ❑ Dramamine
- ❑ Hydrocortisone cream
- ❑ Pepto-Bismol
- ❑ Topical Sunburn Ointment
- ❑ Imodium AD
- ❑ Neosporin
- ❑ Caladryl Lotion
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____

Parent's/Guardian's Signature: _____
Date: ___/___/___

This form will be kept on file only for the purpose of this retreat and then will be destroyed.
This form is a confidential document to be seen only by those who "need to know" for the health and welfare of the student listed.