CHILD'S EXTENDED MEDICAL
AUTHORIZATION AND RELEASE FORM

The Lamb's Chapel @ Haw River Christian Church
415 Roxboro Street, Haw River, NC 27258 336-578-0291

_____
CHILD'S NAME

Home Phone # (_____) _____
Mom's
Cell # (_____) _____
Dad's
Cell # (_____) _____

PURPOSE OF THIS FORM:
This form gives licensed physician consent to give treatment in the case of an emergency while the Minor (under 18 years of age) listed here is involved with any event or trip associated with The Lamb's Chapel @ Haw River Christian Church. If an emergency arises, every effort will be made to notify the parent or guardian. This form also gives permission for an authorized adult chaperon to administer any needed medications as listed below. This form releases the church, church officials, members and adult chaperones of any liability in the event a student is injured or has a medical emergency that occurs while on a church-related trip. This form is good for one year following the stated date of signature.

As the parent/legal guardian of the minor listed here, I have read all the literature about the event/trip and give permission for my child to attend and participate in all the events. I furthermore authorize the Pastor, Associate Pastor, Youth or Children's Pastor and/or other adult chaperones to seek medical treatment for my child if necessary.

Signature of Parent/Guardian _____

Please print above name: _____ Date: _____/ _____/ _____

Minor's Full Name:_____ Date of Birth___ / ____/ ____ Grade _____

Address:_____ State_____ Zip _____

Emergency Telephone Numbers: 1. _____ 2. _____
(Can be parents' work numbers, grandparents or another relative to contact in case one parent cannot be reached at the numbers listed above)

E-mail address:
_____

MEDICAL INFORMATION FOR MINOR LISTED:

If minor attendee needs any medicine while on the trip in conjunction with this church, including over the counter medicine, please be certain that the medicine is labeled and the directions for administering it are given to an adult chaperone. Medicine will be maintained by an adult. Be sure to give instructions if the minor has an allergy to insect bites or any other allergies and conditions.

ALLERIGIES:
Please check below IF your child has sensitivity or **allergies** to:
□ Bee Sting □ Nuts □ Dairy □ Latex □ Other_____

Required medications: _____

_____

CONDITIONS: Please check below IF your child has:
□ Asthma □ Diabetes □ Kidney Injuries □ Seizure Disorder □ Heart Condition
□ Other Medical Conditions: _____

Required medications: _____

Other medications:

Physician: _____

Physician's Telephone:_____

Insurance Company: _____

Policy #:_ _____

☐ Please see further medical or other needed information written on the back of this form (or attached to this form)