MEDICAL INFO FORM

River Valley Community Church

I. INSTRUCTION FOR COMPLETING THIS FORM:

- This form **ONLY** needs to be completed once. We will keep them on file until you need to update them.

II. NAME OF TEENAGER(S): MEDICATION ALLERGIES:

1st Teenager's Name: ________________________________ ________________________________

Social Security #: ________ - ______ - ________ Birth Date: ______ / ______ / ______

2nd Teenager's Name: ________________________________ ________________________________

Social Security #: ________ - ______ - ________ Birth Date: ______ / ______ / ______

3rd Teenager's Name: ________________________________ ________________________________

Social Security #: ________ - ______ - ________ Birth Date: ______ / ______ / ______

III. PHONE NUMBERS:

Phone #: (________) - ________ - ____________ Phone #: (________) - ________ - ____________

Is this your ❑ home #, ❑ cell # or ❑ work #? *Is this your ❑ home #, ❑ cell # or ❑ work #?*

Phone #: (________) - ________ - ____________ Phone #: (________) - ________ - ____________

Is this your ❑ home #, ❑ cell # or ❑ work #? *Is this your ❑ home #, ❑ cell # or ❑ work #?*

IV. INSURANCE INFORMATION:

- Please provide a front and back copy of your insurance card with this form.

Company Name: ____ Account #: ________________

Group Number: ________________________ Contract #: ________________________

V. MEDICAL TREATMENT AUTHORIZATION:

In the event of an emergency where medical treatment is required I give my permission to River Valley Community Church or adult chaperons to obtain the services of a licensed physician for the **Minor(s)** listed above. I understand that all efforts will be made to contact me immediately concerning any such emergency.

________________________________ ________________________________ ______________

Printed Name of Parent or Legal Guardian *Signature of Parent or Legal Guardian* *Date*

VI. OVER THE COUNTER MEDICATION AUTHORIZATION:

I understand that the dosage given will be equal to or less than the prescribed amount indicated on the label. I hereby release and forever discharge River Valley Community Church or adult chaperons from any liability in administering the following over the counter medications I have approved. I give my permission to River Valley Community Church or adult chaperons to administer or apply the following over the counter medications for the **Minor(s)** listed above in the event it becomes necessary.

________________________________ ________________________________ ________________

Printed Name of Parent or Legal Guardian *Signature of Parent or Legal Guardian* *Date*

Please Initial For Your Approval:

______ Acetaminophen (Tylenol, etc.)

______ Allergy Medication or Cream (Benedryl, etc.)

______ Antibiotic Cream or Ointment (Neosporin, etc.)

______ Cold Medication (Benedryl, Dimetapp, etc.)

______ Eye Drops

______ Hydrocortisone Cream

______ Ibuprofen (Motrin, Advil, etc.)

______ Petroleum Jelly

______ Rash Ointment or Cream (Desitin, A&D, etc.)

______ Other: ________________________

VII. PRESCRIPTION MEDICATION AUTHORIZATION:

I give my permission for the authorized River Valley Community Church adult chaperons to administer or apply the above prescription medication. I understand it is my responsibility to request the correct dosage amounts and that the medications are in the original container and were prescribed for the above named child. I hereby release and forever discharge River Valley Community Church or adult chaperons from any liability in administering the above prescription medication.

________________________________ ________________________________ ________________

Printed Name of Parent or Legal Guardian *Signature of Parent or Legal Guardian* *Date*

Name of Medication: ________________________________ Dosage Amount: ____________________

Time(s) To Be Administered: ____

Instructions (by mouth, apply to skin, inhale, drops in eyes, etc.): ________________________________