

### Medical Release Form for Youth@General Synod

To be completed by all youth and adult participants of the Youth@General Synod 2011 Program.  
Youth Group Coordinators, please keep originals with your files during trip. **Email\*** a PDF copy to **middletonw@ucc.org** or  
**Fax\*** one copy to Attn: Waltrina Middleton, Youth@GS, (216) 736-3818 (\*along with one copy of all Covenants).

Name: \_\_\_\_\_  
Last First

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ School Grade in Fall 2011: \_\_\_\_\_

Gender: [ ]F [ ]M [ ]Trans\* (\*If not out, please check the gender you usually present)

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Church: \_\_\_\_\_ Church City: \_\_\_\_\_

Conference : \_\_\_\_\_ Region: \_\_\_\_\_

Primary Emergency Contact for youth (Parent/Guardian); for adults (Spouse/Partner/Family/Friend):  
Name: \_\_\_\_\_

Cell number: \_\_\_\_\_ Home/other contact number(s): \_\_\_\_\_

Other Emergency Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell number(s): \_\_\_\_\_ Other contact number(s): \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Current medications: List name, dosage, frequency. (if needed use additional sheet)

For Parents/Legal Guardian: [ ] Youth may self-administer above medications.

[ ] Group Coordinator or designated chaperone may assist as needed.

Permission is [ ] or is not [ ] granted [**check one**] for this youth to receive OTC medications from trip coordinator as needed. **Parent/Legal Guardian initials:** \_\_\_\_\_

Health History: List all conditions, including but not limited to allergies, sleepwalking, convulsions, diabetes, mononucleosis, epilepsy, mobility issues, emotional problems or hyperactivity, fatigue, headaches, dizziness. Please indicate how long since last occurrence of problem. Use additional paper if necessary.

By signing this form I verify that the health/medical and insurance information provided on this form is true, accurate and complete. In case of medical emergency, I give permission to the physician(s) selected by my/my youth's group coordinator to secure proper medical treatment for the participant named on this form. I agree to pay additional costs that arise from such medical treatment if not covered by insurance.

Signature of Parent/Legal Guardian (for youth); or Adult Participant: \_\_\_\_\_