Revised 4/10/2023

Name(Last, First):___________________________

FAIRVIEW CHURCH
LOVE • GROW • SERVE

Health Form / Permission / Liability Release

Minor's Name:____ Grade:____________
DOB:_______________ Gender (M/F):_____ Home Phone:______________ Cell Phone:_____________
Address____
____

Primary Parent/Guardian:________________________________ Home Phone:__________________
Address:____ Work Phone:__________________
City:__________________ State:________ Zip:____________ Cell Phone:___________________
Email: ____

(if applicable)
Secondary Parent/Guardian:_______________________________ Home Phone:__________________
Address:____ Work Phone:__________________
City:__________________ State:________ Zip:______________ Cell Phone:__________________
Email: ____

Other Emergency Contact: __________________________________ Relationship:________________
Home Phone:___________________ Work Phone: __________________ Cell Phone:__________________

Insurance Company: ______________________________________ Policy #:_________________
Insurance Subscriber's Name:______________________________ Group #:_________________
Insurance Claims Address:____
Pre-Authorization Phone Number, if required:____

Physician: _______________________________________ Phone No._________________________
Dentist: ____ Phone No._________________________
Orthodontist: ____________________________________Phone No._________________________

Has minor ever had the following? If so, give the date.

Ear Infection___________ Chicken Pox___________ Measles____________ Diabetes______________
Frequent Headaches_______ Mumps_______________ Convulsions_______ Bleeding ______________
Disorders_______________ ADD/ADHD__________ Fainting__________ Cancer________________
Mouth Braces____________ Serious Injuries________________________ Immune Disorders______
Heart Defect/Disease______ Breathing Difficulties (Asthma, COPD) __________
Operations______________________________ Other:____

Has minor ever had an allergic reaction to: (describe)
Hay Fever_____________ Poison Ivy____________ Insect Sting__________ Penicillin______________
Other Medications (please list):____
Foods:____
Does minor require an EPI Pen _____or inhaler_____ If so, will they be bringing this item with them?________.
If yes, do they know how to use it?_________

Does minor have any other special considerations? (emotional or behavioral concerns, special diet, etc.)

(For Females)
Has student menstruated?______ If no, has she been told about it?_______ Is menstrual history normal?_____

Immunization History- Give date of most recent immunization or booster:
Tuberculin Test__________ Tetanus__________ Polio________ Mumps________ Measles__________
Rubella__________ DPT__________ Hepatitis B_________ Meningitis________ Other_________________

Over-The-Counter Medication: By checking below, you give permission for an adult designated by the Ministry Staff Leader to administer over the counter medications as needed according to the specific directions on the product label unless otherwise directed by a physician. These may include: Acetaminophen (Tylenol), Ibuprofen, Excedrin, Midol, Maalox, Mylanta, Pepto Bismol, Kaopectate, Imodium, Benadryl, Sore Throat Lozenges, Hydrocortisone Cream, Calamine Lotion, Insect Bite Relief, Insect Repellent Containing DEET, Sunscreen, or other medications as deemed necessary by the designated adult.

_______My child may receive **ALL** over the counter medications as needed
_______My child may receive all **EXCEPT** the following:____
_______My child may receive **ONLY** the following:____
_______My child may **NOT** receive any over the counter medications

Will your child be bringing medication?______________. If prescription medications are needed to be brought with them, contact your child's Ministry Staff Leader for further handling details.

Prescription and Routine Medications- Please list all medications to be taken regularly. List exact dosage and dispensing orders prescribed by your doctor. Medication must be in original containers.

Medication	Dosage	Times Taken (Breakfast, Lunch, Supper, Bedtime, Other)

Revised 4/9/2023

The following must be signed under witness of a Notary Public:

I____________________________, parent or legal guardian of _______________________________, a minor under the age of 18, give my consent for the minor named above to participate in all events and activities organized by Fairview Church . I also give consent for the Pastors, Ministers, paid staff members, or other adult volunteers (over the age of 18) to sign for any reasonable medical attention deemed necessary by a licensed physician for the minor should it become necessary. By signing below, I release the church, its employees, and volunteers of any, and all liability for injury, loss, or damage to person or property during the course of his/her involvement in the activities or medical treatment. I also acknowledge that the health insurance information provided above is accurate and I will be fully responsible for any, and all costs of medical treatment and/or property damage caused by the student. Further, I agree to bring the minor home at my expense should they become ill or if deemed otherwise necessary by the Pastor, Ministers, or paid staff members. This consent will remain in effect unless rescinded in writing and acknowledged by the return of this original form to the parent or guardian.

Parent/Guardian Signature____

The above signed appeared before me, a Notary Public of_______________________ County,
in the state of ________________________.
Witness my hand and official seal this _________day of ________________, 20___.

Notary Public____
My Commission Expires____