

PARAMOUNT CARE FOUNDATION

Afterschool Program
Mandatory Health Form

2017-2018

School _____

Grade: _____

Child's School _____

(Please Print)

Name of Student _____ Date of Birth _____

Address _____ Age _____

City _____ State _____ Zip _____

Phone # (____) _____ - _____ Sex ____ Height _____ Weight _____

Emergency Contact Person:

Parent/Guardian Name _____

Address (if different from student) _____

City _____ State _____ Zip _____

Phone #(Home)(____) _____ - _____ (Work) (____) _____ - _____

Cell Phone # (____) _____ - _____

E-mail _____

Alternate Contact Person" (Use someone near the primary contact)

Name _____

Address _____

Town _____ State _____ Zip _____

Phone #(Home)(____) _____ - _____ (Work) (____) _____ - _____

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity.

Do you have health insurance? _____ Yes _____ No

Name of insurance company _____

Policy # _____ Group # _____

In whose name is the insurance? _____

Family Doctor _____

City/Town _____ Phone# (____) _____ - _____

If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him/her proper medical care during his/her time with the youth ministry activity.

Health History

Any pre-existing or present medical conditions: _____

Name and dosage of any medications that must be taken _____

Any allergies? _____
to Medications? _____

_____ Hay fever _____ Heart Condition _____ Diabetes _____ Insect Stings

_____ Epilepsy/Nervous Disorders _____ Asthma _____ Frequent stomach upsets

_____ Physical Handicap _____ Any major Illnesses during the past year _____

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions) _____

Date of last Tetanus shot _____ contact Lenses? _____

Any swimming restrictions? _____ No _____ Yes What? _____

Any activity restrictions? _____ No _____ Yes What? _____

Parent Medical and Liability Release Statement:

*I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during the activity dates shown on this form, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or order an injection, anesthesia, or surgery for my child as deemed necessary.

*I understand all reasonable safety precautions will be take at all times by Paramount Care Foundation/Emmanuel Reformed Church, and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Paramount Care Foundation or Emmanuel Reformed Church, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

Parent/Guardian Signature _____ Date _____

I give permission to take and publish pictures from my child to use in PCF advertising materials. _____ Initials

This form shall be in effect from September 2017 to June 2018, unless revoked sooner in writing.