



OAK HILL FELLOWSHIP STUDENT RELEASES & MEDICAL FORM

Effective Dates: _____ - _____

STUDENT INFORMATION:

Name: _____ Birthday (mm/dd/yyyy) _____ Male Female

LAST FIRST MIDDLE

School: _____ Current Grade: _____ Student's Email: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Student's Home Phone: _____ Student's Cell Phone: _____

PARENT/GUARDIAN INFORMATION:

Mother's Name: _____ Home Phone: _____ Cell: _____ Work: _____

Mother's Email: _____

Mother's Address (if different than student's): _____ State: _____ Zip: _____

Father's Name: _____ Home Phone: _____ Cell: _____ Work: _____

Father's Email: _____

Father's Address (if different than student's): _____ State: _____ Zip: _____

Do both parents have custody? Yes No If not, who is the custodial parent/guardian? _____

EMERGENCY CONTACT INFORMATION:

Parents will be the first contact. However, in the event parents cannot be reached, we will inform the following people:

Full Name: _____ Relationship to Student: _____

Home #: _____ Cell #: _____ Work #: _____

Full Name: _____ Relationship to Student: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Medical Insurance Company: _____ Policy #: _____

Policy Holder's Name: _____

Primary Care Doctor/Provider: _____ Office Phone: _____

Dentist: _____ Office Phone: _____

ALLERGIES

(Please be as specific as possible)

Insect Stings/Reactions: _____

Food Allergies/Reactions: _____

Medication Allergies: _____

Prescribed EpiPen: _____

- Student can self-administer EpiPen? Yes No

HEALTH HISTORY:

(Please check all that apply)

- _____ Seasonal Allergies
- _____ Blood Disorders
- _____ Hypertension
- _____ Frequent Ear Infections
- _____ Psychiatric Treatment
- _____ Seizures/convulsions
- _____ Heart Defect/Disease
- _____ Mononucleosis
- _____ Diabetes
 - On insulin? Yes No
 - Glucose Testing? Yes No
- _____ Asthma
 - Use of inhaler? Yes No
- _____ Other conditions not listed above
(Please Explain) _____

PRESCRIBED MEDICATIONS:

Please list any medications taken routinely, along with the dosage and frequency.

- Medicine 1: _____
- _____
- Medicine 2: _____
- _____
- Medicine 3: _____
- _____

OVER-THE-COUNTER MEDICINES:

Do we have your permission to give your student Acetaminophen or Ibuprofen according to the prescribed dosages listed on the bottle if they complain of minor headaches, cramps, or other aches/pains?

Yes No

OTHER MEDICAL INFORMATION:

Basic first aid will be administered as needed, unless noted by the parent. Please explain below if you wish to decline. _____

Does your student wear: Glasses Contact Lenses

Date of last tetanus shot: _____ Approximate Height: _____ Approximate Weight: _____

Please explain if this student’s activities should be restricted for any reason: _____

PARENTAL CONSENT & WAIVER:

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases Oak Hill Fellowship (hereinafter the “Church”) and its staff of any liability against personal losses of named student. Every effort will be made to ensure the safety of your student; however, accidents and injuries may occur even when precautions are taken. I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events organized by Oak Hill Fellowship. I/We understand that there are inherent risks involved in any activity, and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our student’s involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. I also agree to place my student in the care of Oak Hill Fellowship staff and volunteers, understanding that my student is subject to the Church’s rules and regulations. I understand that, if my student fails to adhere to any verbal or written rules, the staff and volunteers reserve the right to send my student home and not refund any money that may have been collected for an activity.

_____ **PHOTO/VIDEO:** I give my permission for any photographs or video taken of my student in conjunction with Oak Hill Fellowship to be used in any highlight presentations, Sunday morning worship services, and/or future promotional materials.

PRIVACY POLICY: Oak Hill Fellowship values your privacy and will not sell, rent, or otherwise give out your personal information (including photographs or videos of your student) for use outside of Oak Hill Fellowship purposes.

Parent/guardian signature: _____ Date: _____