OAK HILL FELLOWSHIP
STUDENT RELEASES & MEDICAL FORM

Effective Dates: ____________________ – September 01, 2020

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-admisiter 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
Int 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: ________________