

FIRST ARP YOUTH MEDICAL FORM

STUDENT'S NAME _____

SEX M _____ F _____

PARENT'S NAMES _____

HOME NUMBER _____

CELL NUMBER _____

EMERGENCY CONTACT/NUMBER _____

ADDRESS _____

EMAIL _____

STUDENT'S DATE OF BIRTH _____

GRADE _____

INSURANCE INFORMATION

GROUP _____

POLICY NUMBER _____

PHONE NUMBER _____

ALLERGIES _____

MEDICATIONS _____

DATE OF LAST TETNUS SHOT _____

ANY SPECIFIC ACTIVITIES TO BE RESTRICTED FROM _____

SPECIAL NOTES _____

THSIRT SIZE _____

*IF A VISITOR-WHO ARE YOU ATTENDING WITH? _____

MEDICAL AUTHORIZATION AND RELEASE: In case of medical emergency I understand every reasonable effort will be made to contact parents or guardians of participants, using the information set forth above. In the event parents or guardians cannot be reached, I give permission to the physicians and hospitals selected by the group leader to administer to the child named above the medical and surgical treatment then believed to be in the best interest of the child. The medical information on this form is complete and correct. I shall not hold the leaders of First ARP liable for any injury to my child while on a youth event/trip. I certify that I am authorized to grant this authority and release.

PARENT'S SIGNATURE _____

DATE _____

PLEASE INCLUDE PAYMENT FOR THE EVENT/TRIP WITH THIS MEDICAL FORM.