Medical Release Form

Potomac Presbyterian Church
10301 River Road, Potomac, MD, 20854

Participant's Name:_____ Birth date:_____ Home phone #: _____

Home Address, City, State, Zip: _____

Mother's Name: _____ Mother's Cell Phone #:_____

Father's Name: _____ Father's Cell Phone #:_____

Health Insurance Plan: _____ Policy #: _____
Please attach a copy of both the front and back of the health insurance card.

Person to contact in case of emergency when parents cannot be reached:

Name:_____ Relationship: _____

Home phone #: _____ Cell Phone #:_____

Participant's known allergies, including medicine or food allergies: _____
Does your child/ youth carry an epi-pen? Yes_____ No_____
May PPC leadership give your child/ youth their epi-pen if deemed necessary? Yes_____ No_____

Dietary Restrictions: _____

Participant has the following medical concerns of which adult supervisors should be aware (motion sickness, diabetes, seizure disorders, etc.):_____

Please list any medicines participant takes on a regular basis: _____

May PPC leadership give your child/ youth over the counter medications such as ibuprofen, acetaminophen, diaper rash cream, and/or sunscreen? Yes_____ No_____ Date of participant's last tetanus shot: _____

Name of primary care physician: _____ Physician's Phone #: _____

Physician's Address, City, State, Zip: _____

Physician And/ Or Hospital Permission Statement

I consent to first aid or emergency treatment of my son/ daughter, _____, including admittance to the nearest physician and/or hospital for medical treatment, the use of x-rays or other diagnostic procedures, and the administration of medications, if the need should arise while my son/ daughter is engaged in a Potomac Presbyterian Church sponsored activity or trip and/or the supervising staff or volunteers of Potomac Presbyterian Church deem it necessary. I consent to pay for any and all related medical and hospital expense associated with such first aid and emergency medical treatment. I further represent and warrant that my son/ daughter has adequate medical, health and/or other insurance coverage for participation. The physician and/or hospital will use this permission statement as authority to administer medication and/or treat my son/ daughter, _____, if necessary.

Signature of parent/ guardian: _____ Date: _____

Name of Parent/Legal Guardian: _____