Ohio Conference of Seventh-day Adventists
Medical Consent Form

Guardian and Emergency Contact Information

This form must be filled out at the beginning of every year to cover the activities for the year.
A copy of each student's form must be taken on off-campus activities.

Please print.

Attendee's Name ______________________ S.S. # ______________ Age _____ D.O.B. ___/___/___ Gender: M F
(Month Day Year)

Address ____
Street City St Zip

Parent/Guardian Name ______________________________ Relationship ______________

Father/Guardian ______________________ Work Phone ______________ Home Phone ______________

Mother/Guardian ______________________ Work Phone ______________ Home Phone ______________

Emergency Contact ______________________ Work Phone ______________ Home Phone ______________

Attendee's Health Record and Medical Information

Attendee's Physician's Name ______________________________ Physician's Phone ( ) ______________

Insurance Carrier ______________________ Health Card No. ______________ Group No. ______________

Does the attendee have any medical restrictions? ❒ Yes ❒ No

Explain: ______________________

Does the attendee have any activity restrictions? ❒ Yes ❒ No

Explain: ______________________

History

- ❒ Sore Throats
- ❒ Sinusitis
- ❒ Bronchitis
- ❒ Fainting
- ❒ Upset Stomach
- ❒ Kidney Trouble
- ❒ Convulsions
- ❒ Sleepwalking
- ❒ Heart Trouble
- ❒ Diabetes
- ❒ Asthma
- ❒ Bedwetting
- ❒ Dietary restrictions
- ❒ Psychological needs

Explanations: ______________________

Shots

Date of last tetanus shot ______________

Allergies - List specifics.

- ❒ Drugs ______________
- ❒ Food ______________
- ❒ Plants ______________
- ❒ Animals ______________
- ❒ Bee/Insect stings ______________
- ❒ Dietary restrictions ______________
- ❒ Other ______________

Anidote:
- ❒ Nurse Administered
- ❒ Self Care

Medications

Is the attendee currently taking medications? ❒ Yes ❒ No

Explain: ____

Drug Name: ______________________ Dosage: ______________________

Drug Name: ______________________ Dosage: ______________________

Drug Name: ______________________ Dosage: ______________________

Medical and Liability Release

I am applying to participate in an activity of the Youth Ministries Department as scheduled by the Ohio Conference of Seventh-day Adventists, and I will abide by all Ohio Laws, rules, regulations, policies and directives of the officials of the Ohio Conference. I consent and give the Ohio Conference authority and permission to select a medical treatment facility, physician, and all necessary emergency medical care required in case of an accident or emergency illness for me/or my minor child.

Note: I understand every effort will be made to contact me in case of an emergency. However, in the event that I cannot be reached, I will hold the Ohio Conference forever harmless for supervising all required emergency care. I will be responsible for all payments of all treatments, hospitalization, anesthesia or surgery in respect to the emergency care on my behalf. (Parent/Guardian signature required for person under the age of 18 years old).

Attendee's Signature: ______________________________ Date ______________

Parent/Guardian Signature: ______________________________ Date ______________