Church in NYC Young People's Retreat, February 16-18, 2020
Kingston Penuel Christian Center
Medical Release Form

Directions: Please fill out this form and hand it to your district/locality's registration coordinator.

Participant Name: _____

Participant Date of Birth: _____ Participant's current school grade: _____

Parent/Guardian Name: _____

Address: _____

Emergency Contact Name: _____ Telephone Number: _____

Church Locality/ District: _____

Health and Medical Information (Please answer all questions)

Participant's Height: _____ ft _____ in

Participant's Weight: _____ lbs (needed for proper dosage of OTC medications)

Please check all that apply:

- ▢ **Medication Allergy:** If yes, please list name of medication and reaction symptoms

  Medication: _____

  Symptoms:_____

- ▢ **Food Allergy:** If yes, please list names of foods, symptoms, and epi-pen availability**

  Allergic Foods:_____

  Symptoms:_____

- ▢ **My child/YP has an Epi-pen and will bring it to KPCC. (All participants with food allergies must bring their own prescribed Epi-pen to KPCC)**

- ▢ **Bee Sting Allergy**

- ▢ **Asthma/Respiratory Condition:** If yes, please list prescribed medication/inhaler and dosage instruction:

  Medication: _____ Dosage: _____

- ▢ **Diabetes:** If yes, please list prescribed medication/inhaler and dosage instruction:

  Medication: _____ Dosage: _____

- ▢ **Seizure:** If yes, please list prescribed medication/inhaler and dosage instruction:

  Medication: _____ Dosage: _____

Continued on reverse side

▢ **Special Needs:** (Attention Deficit Disorder, Autism, Learning Disability etc)

If yes, please describe helpful techniques:_____

_____

_____

Comments- Please share any other Health or Medical related information that will help your child at KPCC**:**

_____

_____

_____

Insurance Information

Provider: _____ Policy Number: _____

Primary Physician's Name: _____

Primary Physician's Number: _____

Authorization for Medical Treatment

I, _____, parent or legal guardian of _____, who is in grade _____, temporarily authorize the bearer of this document to obtain any and all medical and/or emergency care, which in the bearer's opinion is needed by my child. I also accept full responsibility for the payment of any expenses incurred from such medical and/or emergency care.

I also authorize the dispensing of the following over the counter medications to my child. (Check all that apply):

▢ Acetaminophen/Tylenol

▢ Ibuprofen/Advil

▢ Prescribed medication** (**Please provide prescribed medication on arrival to KPCC, name of medication, dosage, and copy of prescription signed by your primary physician.**)

This authorization is effective from and including November 8-10, 2019 for the Northeast Spring Young People's Conference being held at Kingston Penuel Christian Center (KPCC) 288 Hickory Bush Rd, Kingston NY 12401.

Parent/Guardian Name (Print):_____

Parent/Guardian Signature: _____ Date: _____