

# INSURANCE AND HEALTH FORM

Hillside Ministries of Church of the Cross

## Mandatory Health Form

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(Please print)

Name of student \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_ Sex \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

<b>Emergency Contact Person:</b>
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Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # (Home (\_\_\_\_)) \_\_\_\_\_ (Work) (\_\_\_\_) \_\_\_\_\_

<b>Alternate Contact Person</b> (Use someone near the primary contact)
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Name \_\_\_\_\_ Phone # (Home) (\_\_\_\_) \_\_\_\_\_ (Work) (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

**Medical Insurance**

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity.

Do you have health insurance? Yes \_\_\_ No \_\_\_

Name of insurance company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

In whose name is the insurance?  
\_\_\_\_\_

Family doctor \_\_\_\_\_ City \_\_\_\_\_

Phone # \_\_\_\_\_

If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him or her proper medical care during his or her time with the youth ministry activity.

**Health History**

List any pre-existing or present medical conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List name and dosage of any medications that must be taken: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Health History (continued)

Any allergies? \_\_\_\_\_ To medications? \_\_\_\_\_  
hay fever \_\_\_\_\_ heart condition \_\_\_\_\_  
diabetes \_\_\_\_\_ insect stings \_\_\_\_\_  
epilepsy/nervous \_\_\_\_\_ asthma disorders \_\_\_\_\_  
frequent upset stomach \_\_\_\_\_ physical handicap \_\_\_\_\_

Any major illnesses during the past year? \_\_\_\_\_

If any of the above are checked, please give details (for example, include normal treatment of allergic reactions)

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Any activity restrictions?    yes \_\_\_\_\_ no \_\_\_\_\_ What? \_\_\_\_\_

### Parental Medical and Liability Release Statement

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during the activity dates shown on this form, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment, or order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand all reasonable safety precautions will be taken at all times by Church of the Cross and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold COTC, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Student (if over 18 years of age) \_\_\_\_\_