BRYN MAWR PRESBYTERIAN CHURCH
[illegible] | Bryn Mawr, Pennsylvania, 19010 | [illegible] | Fax: [illegible]

MEDICAL FORM

Complete this form and return it to the Church office. To ensure that your child receives proper medical care. contact us immediately to update the form of any medical information changes or for specific events/trips,

Complete one form per registrant; please print clearly

Participant's Last Name_____ Participant's First Name _____

Participant's Date of Birth *(MM/DD/YYYY)* _____ Participant's Age _____

Parent(s)/Guardian_____

Home Phone _____ Cell Phone _____ Work Phone _____ E-Mail _____

Home Address_____ City _____ State _____ Zip _____

MEDICAL TREATMENT PERMISSION & RELEASE

I desire my child to participate in the Bryn Mawr Presbyterian activity described herein ("the Program"). I understand that there are hazards and risks, as well as benefits, associated with my child's participation in the Program. In consideration of the benefits of my child's participation in the Program, I, on behalf of myself, my child, my or their heirs, executors, administrators, agents, assigns, and other personal representatives, irrevocably and unconditionally remise, release, settle, compromise, and forever discharge any and all manner of suits, actions, causes of action, damages and claims, known and unknown, that I or my child, have or may have against Bryn Mawr Presbyterian Church and/or its trustees, officers, employees, agents assigns, contractors, or volunteers arising from or connected with my child's participation in the Program, including the securing of medical treatment for my child during my child's participation in the Program.

I give my permission to Bryn Mawr Presbyterian Church, its employees, agents, assigns, contractors, or volunteer supervisors to secure medical treatment for my child in the event that such treatment is needed during my child's participation in the Program or related activities. I agree to assume financial responsibility for the cost of such treatment.

The laws of the Commonwealth of Pennsylvania shall apply to this Medical Treatment Permission & Release. If any of the provisions, terms, clauses, or waivers or releases of claims or rights contained herein are declared illegal, unenforceable, or ineffective in a legal or other forum or proceeding, such provisions, terms, clauses or waivers and releases shall be deemed servable, and all other provisions, terms, clauses and waivers and releases of claims and rights contained herein shall remain valid and binding.

I sign this document with the intent to be legally bound by it. I am an adult, competent to sign this document. I am signing this document voluntarily. I have read it and I understand its contents.

Parent(s)/Guardian Name *(please print)* _____

Parent(s)/Guardian Name *(signature)* _____ Date _____

EMERGENCY CONTACT INFORMATION

Parent(s)/Guardian Name_____

Home Phone _____ Cell Phone _____ Work Phone _____ E-Mail _____

Contact Name_____ Relation _____

Home Phone _____ Cell Phone _____ Work Phone _____

Contact Name_____ Relation _____

Home Phone _____ Cell Phone _____ Work Phone _____

Registration, Medical and Name/Image Release Forms are Available at www.bmpc.org

MEDICAL FORM

INSURANCE INFORMATION

Participant's Last Name_____ Participant's First Name _____

Name of Insurance Policy Holder _____

Carrier _____ Policy # _____ Group # _____

PHYSICIAN INFORMATION

Physician's Name/Practice _____

Phone _____ FAX _____ E-Mail _____

Office Location _____ City _____ State _____ Zip _____

MEDICAL CONDITIONS

PLEASE CHECK ALL THAT APPLY

_____ ADD
_____ ADHD
_____ Asthma
_____ Cardiac Problems
_____ Chronic Bed Wetting
_____ Contact Lenses
_____ Diabetes
_____ Dizziness/Fainting/Blackouts
_____ Eating Disorders
_____ Epilepsy
_____ Mental Health Problems
_____ Motion Sickness
_____ Orthopedic Problems
_____ Stomach Problems
_____ *(If applicable)* Has your daughter had her first menstrual period?

DATE of LAST TETANUS SHOT_____

ALLERGIES *(Check)*	REACTION *(Describe)*	TREATMENT *(Medication/Dosage)*
_____Aspirin	_____	_____
_____Food Allergies	_____	_____
_____Insect Stings	_____	_____
_____Latex	_____	_____
_____Other Medication	_____	_____
_____Other Medication	_____	_____
_____Penicillin	_____	_____
_____Sulfa	_____	_____
_____Tetracycline	_____	_____

SPECIAL MEDICATION: ***This information will be kept confidential. Please specify all medication(s) your child/student is currently taking, the dosage and how often it should be administered. Please note that we will not administer any medication during program hours unless we have written permission from you and your child/student's physician. Please be sure to supply any medication necessary for your child. All medications should be clearly labeled with name and instructions and placed in a sealed, clear plastic bag.*** _____

_____

ANY ACTIVITY RESTRICTIONS: _____

IMPORTANT: We are unable to dispense any medication without documentation from your child's doctor. This includes: aspirin, acetaminophen, ibuprofen, Benadryl, Epi-Pen.