



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 _____ Age _____ D.O.B. ____/____/____ Gender: M F
Month Day Year

Address _____
Street City State Zip

Guardian/Father _____ Phone _____ Alt. Phone _____

Guardian/Mother _____ Phone _____ Alt. Phone _____

Church Name _____ Club Name _____

Area DET (North South) KFW CTX (North South) HBA (North South) VCB

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 Does the attendee have any activity restrictions? Yes No

Explain: _____ Explain: _____

History

Tetanus and Temp

Allergies - List specifics

- | | |
|---|---|
| <input type="checkbox"/> No Known History | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Dietary restrictions |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Psychological needs |
| <input type="checkbox"/> Other: _____ | |

Date of last tetanus shot _____

Temperature _____

Within normal limits (97° - 99° F)

- | | |
|---|---|
| <input type="checkbox"/> No Known Allergies | Antidote: _____ |
| <input type="checkbox"/> Drugs _____ | <input type="checkbox"/> Nurse Administered |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Self Care |
| <input type="checkbox"/> Plants _____ | |
| <input type="checkbox"/> Animals _____ | |
| <input type="checkbox"/> Bee/Insect stings _____ | |
| <input type="checkbox"/> Dietary restrictions _____ | |
| <input type="checkbox"/> Other _____ | |

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 Texas Conference of Seventh-day Adventists, and I will abide by all Texas Laws, rules, regulations, policies and directives of the officials of the Texas Conference. I understand that as an attendee, I may be photographed and videotaped during this event. I hereby give to the Texas Conference Youth Ministries my permission to use this material and release them from all liability and give the rights for publication of said materials for future promotions and advertising. Further, I consent and give the Texas Conference Youth Ministries 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: Every effort will be made to contact me in case of an emergency; however, I will hold the Texas Conference Youth Ministries 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 _____