

**Des Moines Gospel Chapel High School
Medical Information Form**

*Although this is a lengthy form, we need to have the information listed below in case of an emergency.
Thank you for taking the time to fill this out.*

Please complete BOTH SIDES of this form for **EACH** student attending DMGC High School Youth Group Activities. **PRINT** clearly.

Youth's Name _____

Grade in Fall of 2011 _____ Age _____ Male / Female

Address _____

Apartment or Suite # _____

City _____ Zip _____

Emergency Phone _____

Alternate (not the same as above) phone number in case of emergency? _____

Child's Physician? _____ Phone _____

Insurance Provider _____

Policy Number _____

List any current illnesses or medical conditions that may impact your child's time during HS activities: _____

What drugs, if any, is your child allergic to? _____

Date of last tetanus shot? _____

List any known allergies that may impact your child.

Any dietary or other activity restrictions? _____

(Side one of two)

**2011-12 High School Group
PARENTAL / GUARDIAN
CONSENT TO MEDICAL TREATMENT**

(Print above the name of the "MINOR" attending Des Moines Gospel Chapel High School Activities)

(Print name of PARENT or Legal Guardian)

In case of emergency, every effort will be made to contact a PARENT or guardian of the MINOR named above.

The above named PARENT/Guardian of the MINOR has entrusted the MINOR into the care of the HIGH SCHOOL DIRECTORS, while the MINOR participates in an activity sponsored by the Des Moines Gospel Chapel HIGH SCHOOL YOUTH GROUP.

The PARENT/Guardian does hereby authorize the HIGH SCHOOL DIRECTORS to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and/or surgeon licensed under the laws of the State or County in which the medical care is being sought and/or on the medical staff of any hospital.

It is understood that this authorization is given in advance of any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care being required but is given to provide authority and power on the part of the HIGH SCHOOL DIRECTORS to give specific consent to any and all such examination, anesthetic, diagnosis, treatment, or hospital care which the aforementioned surgeon, or physician in the exercise of his/her best judgment, may deem advisable.

The PARENT/Guardian hereby agrees to fully pay all costs of medical or dental care incurred for the benefit of the MINOR by the HIGH SCHOOL DIRECTORS under this authorization.

This authorization will remain effective until **July 1, 2012**.

I have read and agree to the above medical consent,

The above PARENT or legal guardian's signature

Dated

(Side two of two)