

Catalina Foothills Church

COUCH WARS • MAY 29-30 2009

(Please sign top and bottom of form)

Full Name _____ Male/Female _____ Date _____ T-Shirt Size _____

Address _____ City _____ Zip _____ Phone _____

Father's Name & Contact # _____ Mother's Name & Contact # _____

Another emergency # _____ Name & Relationship of Person _____

Function Attending _____ Date(s) _____

School Attending _____ Grade _____ Birthdate _____

Health Insurance Co. & 800-number _____ Policy # _____

Are you allergic to any medication? (Y/N) _____ If so, what? _____

Are you diabetic? (Y/N) _____ When was your last tetanus shot? _____

Medical Conditions: Please list any allergies, physical or dietary restrictions that we need to be aware of: (attach an additional page if necessary) _____

I give permission for my child to attend the above function with Catalina Foothills Church. As soon as possible, parents/guardian will be contacted to inform of any emergencies and/or medical treatments. I give my consent to CFC to provide basic first aid to my child if needed, and to make the decision to transport my child to a hospital or urgent care facility, and for a licensed healthcare professional to administer any emergency care my child may need. In the event that parent/guardian cannot be reached, a CFC staff member will use their best judgment in authorizing any medical treatment/action.

Parent or Guardian Signature _____

AUTHORIZATION TO MEDICATE MINOR STUDENT/STAFF MEMBER

Please circle any of the following Over-The-Counter medications and First Aid products (or generic equivalent) that you would allow CFC staff/medical personnel to administer to your child (according to the manufacturer's directions on container), if needed: *(Medication cannot be given unless circled)*

Tums	Benadryl	Emetrol (anti-nausea)	Cough Drops	Acetaminophen
Ibuprofen	Dayquil	Pepto Bismol Tablets	Insect Repellent	Sun Block
Tylenol	Imodium AD (anti-diarrhea)	Eye Drops	Antibiotic Ointment	

Please complete each line for any prescription or over-the-counter medication sent with your student. All medication must be in the original containers with prescription instructions in the students's name.

NAME OF MEDICATION:	DOSAGE:	FREQUENCY:	WHAT IS IT FOR:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent or Guardian Signature _____