

# Neighborhood Church

## 2023-2024 Youth Ministries Medical Form - (Valid 6/1/23 – 6/1/24)

### **MINOR INFORMATION (please print)**

Full Name of Minor: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Parent / Guardian Full Name(s): \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Parent/Guardian Cell Phone: \_\_\_\_\_  
Parent/ Guardian Email: \_\_\_\_\_  
Gender: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_ Grade: \_\_\_\_ School: \_\_\_\_\_

### **HEALTH / DENTAL INSURANCE INFORMATION**

Health Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Dental Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

### **EMERGENCY CONTACT INFORMATION**

In an emergency, please notify one of the following:

**1)** Name: \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
**1)** Name: \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### **MEDICAL HISTORY**

Has minor had all school-required vaccinations? Yes p No p Date of last tetanus shot: \_\_\_\_\_  
Does minor have a communicable disease or medial condition that may be a risk to others?  
Yes p No p If Yes, Please describe: \_\_\_\_\_  
Does Minor have any drug allergies? Yes p No p If Yes, Please describe: \_\_\_\_\_  
\_\_\_\_\_

Please list the name, dosage, and purpose of medications currently being taken by Minor: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any special considerations regarding Minor (medical conditions, food allergies, dietary restrictions, activity limitations, behavioral issues/concerns, etc): \_\_\_\_\_  
\_\_\_\_\_

**PLEASE COMPLETE THE OTHER SIDE OF THIS FORM**  
**AUTHORIZATION FOR MEDICAL TREATMENT**

As the parent or legal guardian of \_\_\_\_\_ ("Minor"), each of the undersigned gives his or her authorization and consent for the Neighborhood Church of Chico, California (the "Church") and the Church's adult employees, agents, and volunteers (collectively with the Church, the "Neighborhood Parties") to seek, authorize, and consent to such medical or dental care for Minor ("Treatment") as any one or more of them may deem necessary or appropriate. Such Treatment (1) shall be provided upon the advice of and supervision by a physician, surgeon, dentist, or other medical practitioner licensed to practice under the laws of the estate or jurisdiction in which such Treatment is sought, and (2) may include, without limitation, X-ray examination; anesthetic; medical, dental, or surgical diagnosis or treatment; and hospital care. This Authorization for Medical Treatment may be photocopy hereof shall be as valid as an original copy. Each of the undersigned acknowledges and agrees that the Neighborhood Parties shall not be legally or financially liable for any bill or expense incurred in, or any cause of action or claim arising from, the provision of any Treatment or the failure to provide or seek any treatment. In consideration of Minor's participation in one or more events sponsored by the Church, each of the undersigned hereby agrees to indemnify, defend, and hold harmless the Neighborhood Parties from and against any and all losses, damages, liabilities, or expenses (including, without limitation, reasonable attorneys' fees and other costs of defense) in connection with any and all actions, suits, claims, or demands that may be brought or instituted against any Neighborhood Party and arise out of or result from the provision of any treatment or the failure to provide or seek any treatment. This paragraph shall survive any termination or expiration of the Authorization for Medical Treatment for any reason.

Name: \* \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \* \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\* Note: Each person who has legal custody of Minor should sign this Authorization for Medical Treatment, and only a person who signs will be considered a legal custodian of Minor.*

### **Image Authorization**

I grant permission to Neighborhood Church, and its associated Youth Ministry, the right to take photographs and promotional videos of my child during any associated weekly gathering, youth activity, or retreat/camp; and agree that Neighborhood Church and its Youth Ministry may use such photographs for associated websites, social media, or related items.

Name: \* \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \* \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\* Note: Each person who has legal custody of Minor should sign this Authorization, and only a person who signs will be considered a legal custodian of Minor.*