# New Goshenhoppen UCC Youth Information Sheet

**Valid for dates August 1, 20____ through September 30, 20____.**

**PLEASE PRINT CLEARLY**

Name_____ Home phone _____
Address_____ Date of Birth ____/____/____
School_____ Grade_____ Email _____
Do you have any medical conditions; allergies or dietary concerns the Youth Leaders should know about?_____
_____
_____

**Mother's Name**_____ Home Phone _____
Home address _____ Work Phone_____
(If different) Cell Phone _____

**Father's Name**_____ Home Phone _____
Home address _____ Work Phone_____
(If different) Cell Phone _____

Authorization for Treatment:
I request and authorize the Youth Advisors of New Goshenhoppen United Church of Christ, and area hospitals, medical staff personnel, agents and employees, to provide all medical care including but not limited to hospital test, such as pathology, radiology and anesthesia, surgery, and prescriptive drugs advisable for the health of my child. I acknowledge that no representations warranties, or guarantees as to result or cures will be made.

I give____ I do **NOT** give_____ my permission to take acetaminophen (Tylenol) or ibuprofen (Advil) for pain relief for headaches, menstrual cramps, and minor aches and pains. Any other medication, both prescription and over-the-counter, must be brought by your child to the event. Please give him/her a signed note giving your permission to take this medication (name each one) and relevant instructions. In the event I cannot be reached and emergency hospital care/treatment is needed, I understand my child will be taken to the nearest hospital and given emergency care.

Signature of Parent/Guardian_____ Date_____

Student's Physician_____ Phone_____
Student's Dentist/Orthodontist _____ Phone_____
Date of last tetanus shot _____
Your Insurance/major medical company_____
Group or personal policy # __Policyholder's ID #_____

**Please attach photocopies of the front and back of your insurance card.**
**PLEASE NOTIFY NEW GOSHENHOPPEN UCC IF THERE ARE ANY CHANGES TO THIS FORM DURING THE PROGRAM YEAR. THANK YOU.**

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO A THIRD PARTY**

This authorization gives any and all Health Care Providers permission to disclose health information about your child/minor to the named representative of New Goshenhoppen United Church of Christ **August 1, 20____ through September 30, 20____.**

This authorization may be revoked at any time by submitting a written revocation to New Goshenhoppen United Church of Christ.

_____
Name of minor/patient (please print)

In the event of an emergency, every effort will be made to contact the parent or guardian. I understand that if I cannot be contacted, the Church staff will obtain emergency care and I will be responsible for the payment of the expenses that are incurred.

_____ _____
Signature of Parent/Guardian Date

**Please sign under either YES or NO below:**

**YES**

1. I, _____ (Parent/Guardian) hereby authorize any and all Health Care Providers to disclose the specific health information described in #2 below for the purposes, the duration of time, and to the parties described below.
2. Description of the specific information to be disclosed: room/location of patient, laboratory results, billing information, diagnosis, and treatment.
3. Duration of time that the authorization to disclose exists: from **8/1/19 to 9/30/20**.
4. Recipients of the information: Rev. Ryan Travis, New Goshenhoppen United Church of Christ youth group advisors or their designees.

_____ _____
Signature of Parent/Guardian Date

**NO**

I, _____ (Parent/Guardian) choose **NOT** to sign this authorization granting permission for the above stated individuals to act in my place. I will personally pick up and be responsible for the medical treatment of my child as it may become required.

_____ _____
Signature of Parent/ Guardian Date