

## Heritage Presbyterian Church Youth Permission and Release Form

YOUTH NAME (first) \_\_\_\_\_ (last) \_\_\_\_\_

**PARTICIPANT INFORMATION**

YOUTH Cell \_\_\_\_\_ YOUTH E-mail \_\_\_\_\_

School (Middle) \_\_\_\_\_ (High) \_\_\_\_\_ Class of \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Parent/Guardian E-mail(s) \_\_\_\_\_

Parent/Guardian Cell(s) \_\_\_\_\_

Address \_\_\_\_\_

**EMERGENCY CONTACT** (other than parent/guardian; include relationship to youth)

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

Date of birth \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

Known allergies \_\_\_\_\_

Any restrictions (dietary or physical) \_\_\_\_\_

**MEDICATION DISTRIBUTION**

For each current medication, please provide the following information (attach additional sheets as needed):

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time to be taken \_\_\_\_\_ Held by\*: youth adult

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time to be taken \_\_\_\_\_ Held by\*: youth adult

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time to be taken \_\_\_\_\_ Held by\*: youth adult

Additional Instructions \_\_\_\_\_

*Note: ALL medication must be in the original container and verified by the designated adult advisor prior to any trip.  
Any deviation from instructions on container must be noted by doctor or parent in writing.  
\*Any controlled substances must be held by an adult advisor.\**

Please indicate which of the following over-the-counter medications (name brand or generic) may be given to your child:

**(circle) ALL LISTED BELOW** or strike through any medications you **DO NOT** approve to be provided to your child

- |                                      |   |
|--------------------------------------|---|
| Tylenol (acetaminophen)              | Immodium (loperamide HCL)                                 |
| Motrin (ibuprofen)                   | Tums (calcium carbonate)                                  |
| Aleve (naproxen)                     | Pepto Bismal (bismuth subsalicylate)                      |
| Sudafed (phenylephrine HCL)          | Mylanta (simethicone – gas discomfort tabs)               |
| Cough Suppressant (dextromethorphan) | Laxative Tabs (bisacodyl)                                 |
| Decongestant (guaifenesin)           | Neosporin (neomycin sulfate, polymyxin B, and bacitracin) |
| Benadryl (diphenhydramine HCL)       | Other: _____  |

**MEDICAL INSURANCE INFORMATION** (please also attach a photocopy of your insurance card)

Insurance company \_\_\_\_\_

Policy and group numbers \_\_\_\_\_

Employer or provider \_\_\_\_\_

