

# MEDICAL RELEASE FORM – EPISCOPAL DIOCESE OF NEW JERSEY

**Youth's Name and Birthdate:** \_\_\_\_\_

The following is a list of medications that my child, \_\_\_\_\_, will need to take while attending \_\_\_\_\_.  
 (Please attach a list if additional room is needed.) All prescription medication must be properly labeled in its original pharmacy container. Over the counter medication must also have the youth's name written clearly on the container.

**Parent/Guardian Emergency Contact**  
 Name(s) \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone(s) \_\_\_\_\_  
 Cell Phone(s) \_\_\_\_\_

| NAME OF MEDICATION | DOSE | WHEN TAKEN |
|--------------------|------|------------|
| _____              |      |            |
| _____              |      |            |
| _____              |      |            |

**Medical Conditions** \_\_\_\_\_

**Food/Drug Allergies** \_\_\_\_\_

I understand that, except for rescue inhalers and EpiPens, all youth medications will be secured by the event nurse for the duration of the event and made available for my child to take when scheduled.

\_\_\_\_\_  
**Signature of Parent or Guardian** **Date**

The following medication will be available for your child to take with your permission. I, the parent/guardian of \_\_\_\_\_ give permission for my child to take:

- |             |           |          |
|-------------|-----------|----------|
| Cough Drops | Yes _____ | No _____ |
| Tylenol     | Yes _____ | No _____ |
| Motrin      | Yes _____ | No _____ |
| Mylanta     | Yes _____ | No _____ |
| Benadryl    | Yes _____ | No _____ |
| Imodium A-D | Yes _____ | No _____ |

*Please check yes or no for each of the listed medications.*

\_\_\_\_\_  
**Signature of Parent or Guardian** **Date**

By my signature of this form, I give permission for all licensed medical and emergency personnel to treat my child, \_\_\_\_\_, for illness or injury experienced during Diocese of New Jersey Youth Events. I give permission for event staff, in my absence, to authorize medical or emergency treatment for my minor child and to pass on to medical or emergency providers the insurance and medical information provided on these forms.

Medical Insurance Co. \_\_\_\_\_  
 ID# \_\_\_\_\_ Group # \_\_\_\_\_  
 Primary MD Name \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent or Guardian** **Date**