# 963 EFFECT, INC.
# STUDENT EMERGENCY MEDICAL CARD

Name _____
Last First Middle

Male _____ Female _____ Date of Birth _____ Age _____ Grade _____

Primary Residence _____

_____ Home Phone _____
City State Zip Code

Location of Trip _____ Trip Dates _____

Circle one: Parents Married/Parents Separated/Parents Divorced/Father Deceased/Mother Deceased

Who has legal custody? _____
Student resides with: Father ___ Mother ___ Stepfather ___Stepmother ___ Other _____

_____ _____ _____
Father's Name Business Phone Mobile Phone

_____ _____ _____
Mother's Name Business Phone Mobile Phone

Emergency Contacts to call (and to whom we may release child if parents can not be reached). **Two are required**:

_____ _____ _____
Name (Relationship to Applicant) Home Phone Mobile Phone

_____ _____ _____
Name (Relationship to Applicant) Home Phone Mobile Phone

Physician's Name _____ Phone _____

Does the applicant have any history of:

Yes No Heart Problems If yes, describe:_____

Yes No Kidney Problems If yes, describe:_____

Yes No Lung Problems If yes, describe: _____

If medications need to be taken on this trip, the student and parent must let the team leader know in advance. With certain medical conditions, (e.g. diabetes, asthma, severe allergy) emergency medications may be kept with the student. My child may take the following medications as needed while participating in this mission trip. I understand that the manufacturer's label dosage directions will be followed.

Yes No Benadryl for allergic reactions
Yes No Tums
Yes No Motrin/Advil (Ibuprofen)
Yes No Tylenol (Acetaminophen)
Yes No Polysporin or Neosporin Antibiotic Ointment
Yes No Cough Drops
Yes No Sting Stop Swabs
Yes No Calamine or Caladryl Lotion
Yes No Cortaid Anti-Itch Cream (Hydrocortisone)

Yes No Is the applicant allergic to any form of medication? List all allergies to medication and describe the reaction to the medication. _____
_____

Yes No Does the applicant have any other allergies? List all allergies to foods, plants, medicines, bees, or other. Describe the reaction to this allergy and provide the medication or treatment prescribed for the allergies of this student:
_____
_____

Yes No Does the applicant have any health conditions or medical problems of which the team leaders should be aware, (including limitations of activities, attention or emotional concerns, special diet, etc)? If yes, list the condition and treatment.
_____
_____

Yes No Does the applicant have diagnosed asthma? If yes, list treatment prescribed (daily and for emergency).
_____
_____

Yes No Does the applicant take any medications daily? If yes, list the name of the medication, dosage, and reason for medication. _____
_____

Yes No Does the applicant take medications often, but not daily? If yes, list the name of the medication, dosage, and reason for medication. _____
_____

List any other prior injuries, illnesses, and/or surgeries, or other conditions that an EMT or other medical personnel would need to know in case of an emergency. Please tell the age of the child when this even occurred and if he/she required hospitalization:

Injury/Illness/Surgery _____Age_____Date_____
Injury/Illness/Surgery _____Age_____Date_____
Injury/Illness/Surgery _____Age_____Date_____
Injury/Illness/Surgery _____Age_____Date_____

## Authorization and Consent to Administer Over-the-Counter Medications and Medical Treatment

I authorize 963 Effect, through its appointed leaders, to administer first aid or other minor medical treatment including the above referenced over-the-counter medication(s) as shall be deemed best under the circumstances to me or my child. I consent to receive treatment or for my child to receive treatment during the following trip: _____. I understand that 963 Effect will attempt to notify an emergency contact in the event of an emergency requiring immediate medical care for me or my child. If 963 Effect is unable to notify me or the appropriate emergency contact, I give permission for my child to be treated by qualified medical personnel at an emergency clinic, hospital, or other similar medical facility. I release and hold harmless the Board of Directors, as well as any other leader associated with 963 Effect, both individually and in their official capacity(ies), from any liability for administering medications and first aid to or seeking medical care for me and my child. I agree to indemnify and hold harmless 963 Effect, its Board of Directors and leaders, both jointly or severally, from and against any and all claims, damages, causes of action or injuries that arise from the medicating, providing first aid, or seeking emergency medical care for me or my child while participating in the stated trip. I acknowledge that it is my responsibility to keep my records and/or my child's records (phone numbers, work location, emergency contact, health status, and immunization records) current. I also understand that neither general medical nor accident insurance is provided by 963 Effect and that the responsibility for providing such coverage rests with me as parent/guardian for me or my child.

**Insurance Co. Name _____ Name of Insured _____**

**Insurance Co. Address _____**

**ID Number _____ Group Number _____**

(If applicant is not covered under an insurance plan, please write *no insurance*)

_____Date_____ _____ Date_____
Participant's Signature Parent's Signature

_____ Date_____
Parent's Signature

**THESE SIGNATURES MUST BE NOTARIZED**

_____, Notary Public

SEAL

My Commission Expires _____

County _____State _____