



Medical Waiver Form

For individuals involved with The Urban Scholastic Center Ministries

Name _____ **Birth date** _____ / _____ / _____

This form must be read and signed by the participant's parent/guardian if under age 18. **One form per child**

In consideration for being allowed to participate in ministries of The Urban Scholastic Center (hereafter referred to as The USC), I (the parent/guardian) hold harmless and release The USC, its directors, officers, employees, volunteers and agents from liability for any fault, mistake, negligence, or omission causing damage, loss, injury, or bodily injury to me or my child arising from participation with The USC, including any damage arising from the provision of emergency medical treatment. The terms of this Waiver are governed by the laws of the state of Kansas.

In the event I cannot be reached in a case of emergency, I hereby authorize The USC, its officers, directors, agents, employees, or their designated medical professionals to make emergency medical decisions (i.e. doctors, hospitals, medical treatment, etc.) and/or to administer emergency medical assistance. I accept responsibility for payment of expenses incurred as a result of any medical treatment.

THE FOLLOWING INFORMATION WILL BE USED IN CASE OF EMERGENCY

Check all Health Conditions that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Heart/Blood Disease |
| <input type="checkbox"/> Attention Deficit | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Bone Disease/Fractures | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Dietary Regiment |
| <input type="checkbox"/> Contact Lenses/Glasses | <input type="checkbox"/> Frequent Stomach Aches | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Head Injury (previous) | <input type="checkbox"/> Throat Infections |
| <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Other |

List all known Allergies: _____

Please explain any condition(s) checked above and/or other health conditions: _____

List any medications your child takes regularly: _____

Medical Insurance Information (To be used in case of an emergency)

Name of Insurance Carrier: _____

Group Name/Plan Number: _____

Parent/Guardian Signature _____ **Date** _____ / _____ / _____





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STUDENT (FIRST NAME)		(LAST NAME)	
BIRTHDAY:	/ /	AGE:	GRADE:
PARENT (FIRST NAME)		(LAST NAME)	
ADDRESS			
CITY		STATE	ZIP CODE
CELL PHONE ()	HOME ()	WORK ()	
EMAIL ADDRESS			