

St. John's Cathedral Episcopal Church
256 EAST CHURCH ST. JACKSONVILLE, FL 32202 (904) 356-5507

Youth Personal Information Form and Medical Release

Student's Name (one student per form): _____ Birth date: __/__/__
Address: _____ City: _____ Zip: _____
Legal Guardian Name (please print): _____
Student lives with: Both Parents ___ Mother___ Father___ Grandparents___

Parental Contact Information

Home Phone #: _____ Today's Date: __/__/__
Mom Cell #: _____ Dad Cell #: _____
Mom Work #: _____ Dad Work #: _____
Other important #s (give detail if applicable): _____
Mom Email: _____ Dad Email: _____
Other important Email (give detail if applicable): _____

Youth Personal Information

School: _____ Graduation Year: _____
Email: _____
Cell Phone: _____ Best way to contact student: Cell ___ Home ___ Email ___
I check my email: Every day ___ Twice a week ___ Once a week ___ Once a month ___ Never ___ Other ___
Hobbies/Interests: _____
Additional Information: _____

Youth Medical Information

Medical Insurance Company: _____
Policy Group #: _____ Policy ID #: _____
Family Doctor: _____ Phone #: _____
Medications Currently/Recently Taken: 1) _____ from __/__/__ to __/__/__
2) _____ from __/__/__ to __/__/__
3) _____ from __/__/__ to __/__/__
Known Allergies: _____
Additional Information: _____

I hereby release and authorize church staff and volunteers to procure medical assistance for my child should it become needed. I give permission to the medical personnel selected by the church staff and volunteers to order x-rays, tests, treatments, and to provide the necessary related transportation for my son or daughter. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the church staff and volunteers to secure and administer treatment, including hospitalization for my son or daughter. I understand that as a parent I am solely responsible for the correct administration of my son or daughter's medications. Church staff and volunteers are not responsible for the correct administration of my son or daughter's medications. It is my responsibility to make adult volunteers, church staff, and clergy aware of my son or daughter's medical condition, and of all medications he or she is currently taking.

Signature of parent or legal guardian: _____

