

**ST. PAUL CHUNG 2022-2023 CCD STUDENT
MEDICAL INFORMATION & RELEASE FORM**

Student Name: _____ (print) GRADE: _____
(Last, First)

I (Parent or Guardian Name), _____,

am the parent or guardian of _____
(Name of student)

I understand St. Paul Chung Sunday School intends to have First Aid certified/trained individuals during school office hours but cannot guarantee coverage 100% of the time. According to the Code of Virginia (§ 8.01-225) any person who In good faith, renders emergency care or assistance, without compensation, to any ill or injured person at the scene of an accident, fire, or any life-threatening emergency, or en route there from/to any hospital, medical clinic or doctor's office, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such care or assistance is exempt from liability.

I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

Confidentiality Statement: This form will be destroyed NLT 1 January 2024. Access to this form and the information contained is restricted to St. Paul Chung clergy, office personnel, Sunday School teachers and staff for official use only. When not in use it will be stored in a locked cabinet.

CONTAINS PERSONAL INFORMATION. MUST BE STORED IN A LOCKED CABINET WHEN FILLED IN.

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STUDENT NAME:	Date of last Tetanus Booster:
DATE OF BIRTH:	HEIGHT & WEIGHT:
MEDICATION ALLERGIES?	ENVIRONMENTAL ALLERGIES?
CURRENT MEDICATIONS:	
Is the Student authorized to self medicate? (Asthma Inhaler, Epipen, other)	
FOOD ALLERGIES?	DIETARY RESTRICTIONS?
PHYSICAL LIMITATIONS OR RESTRICTIONS?	
ANY OTHER CONDITIONS OR SPECIAL NEEDS?	

Providing the above informational is optional. The intended purpose of this form is to assist medical first responders or hospital personnel in the event a parent or guardian is not available in the event of a medical emergency. Teachers will have knowledge of its contents but **will not** be provided a copy.

Name of Parent/Legal Guardian: (sign)

Date