



## Medical Information and Release Statement

Shiloh Family Ministries (SFM) is a non-profit, non-denominational evangelical organization.  
SFM does not discriminate on the basis of age, sex, marital status, race or national origin.

***This form must be filled out completely. If prospective staff member is a minor, a parent or guardian must sign the waiver. This form MUST be notarized.***

### PERSONAL INFORMATION

1. Name \_\_\_\_\_ Sex (Circle one): Male Female
2. Home Address \_\_\_\_\_
3. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
4. Telephone: Home \_(\_\_\_\_)\_\_\_\_\_ Cell\_(\_\_\_\_)\_\_\_\_\_
5. Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

### MEDICAL INFORMATION

***The following information MUST be completed for the staff member named above.***

1. Is staff member current on all immunizations? ☐ yes ☐ no
2. Has staff member had Chicken Pox? ☐ yes ☐ no
3. Is staff member allergic to any medications? ☐ yes ☐ no (If yes, please list below)  
\_\_\_\_\_
4. Please list any allergies, illnesses or physical conditions that may have a bearing on the staff member's activities with Shiloh Family Ministries (e.g. bee stings, dietary considerations, asthma, etc.) \_\_\_\_\_  
\_\_\_\_\_
5. Please list ALL medications that staff member is currently taking \_\_\_\_\_  
\_\_\_\_\_
6. Has staff member had a physical examination within the last two years? ☐ yes ☐ no  
(If no, please contact your physician.)

No persons under the age of 18 are to be given any medications by Shiloh Family Ministries personnel (including both “over-the-counter” and prescription drugs) without physician’s orders or signed parental (or legal guardian) consent. Upon approval, medications may be dispensed according to these orders and as indicated by the normal dosage requirements for each instance.

If the staff member is a minor, please place a check mark beside each medication listed below that is approved for dispensing. If spaces are left blank, SFM WILL NOT dispense that particular medication unless a physician or parent (legal guardian) is contacted for approval.

\_\_\_\_\_ Acetaminophen (Tylenol)      \_\_\_\_\_ Aspirin      \_\_\_\_\_ Ibuprofen (Advil, Motrin, etc.)  
\_\_\_\_\_ Decongestants      \_\_\_\_\_ Antihistamines      \_\_\_\_\_ Multi-symptom Cold Meds  
\_\_\_\_\_ Pepto Bismol      \_\_\_\_\_ Antacid (Tums, Rolaids, etc.)      \_\_\_\_\_ Anti-Diarrhea (Imodium, etc.)

Family Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Emergency Point of Contact \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_\_) \_\_\_\_\_

### MEDICAL RELEASE

I /We hereby give permission for medical attention to be administered to myself or my/our child who is a minor, by those agents or agencies designated by Shiloh Family Ministries. Where my/our child is a minor, I/we authorize SFM to administer those “over-the-counter” medications indicated by a check mark on the previous part of this form, to my/our child according to the prescribed directions for each medication.

I/We understand that payment for medical bills not directly related to work for myself, or my/our child, who is a minor, are my/our responsibility and that SFM will not be liable for their payment.

I/We agree to waive and release Shiloh Family Ministries, its employees and volunteers from any claim or cause of action that might arise on behalf of myself, or my/our child, who is a minor, as a result of my or his/her participation as an employee, other than a claim for the willful, wanton or reckless misconduct of Shiloh Family Ministries, its employees or its volunteers.

I/We agree to assume all responsibility for my or my/our child’s actions including but not limited to the cost of repair or replacement for items damaged by willful abuse. I/We also agree to assume responsibility to arrange transportation and/or pay for the costs, should it become necessary for myself or for my/our child to be sent home for medical or disciplinary reasons prior to the conclusion of any event or program.

Printed Name of Staff member \_\_\_\_\_

Signature of Staff member \_\_\_\_\_

Date \_\_\_\_\_

***If Staff member is a Minor:***

Printed Name of Parent or Legal Guardian \_\_\_\_\_

Signature of Parent or Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

***NOTE: THIS FORM MUST BE NOTARIZED***

**NOTARY**

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_,  
20\_\_\_\_\_.

By \_\_\_\_\_, who is personally known by me or who  
has produced a \_\_\_\_\_ as identification.

\_\_\_\_\_  
Signature of Notary

SEAL

My Commission expires \_\_\_\_\_