MEDICAL CONSENT FORM

Required by State Law for Students under 18 years of age
PLEASE NOTE: Calvary Community Church does not provide medical or hospital insurance coverage.

Name ________________________________ Birthdate (mo/day/yr) _____/_____/_____ Sex _____ Age _____

Address________________________________Apt #_____ Grade_____ Height __________ Weight __________

City ____________________State __________ Zip __________ Phone (______) __________________________

HEALTH & INSURANCE INFORMATION

Do you carry family medical insurance? Yes No

Name of Responsible Party ____________________________ Relationship_______________ Phone #___________

Address_______________________________ Insurance Company______________________ Policy #___________

Name of Family Physician_______________________________ Phone #____________________________________

Date of Last Tetanus Shot (mo/yr) _____/_____ TB Test (mo/yr) _____/_____ Neg. Pos. Hepatitis _____/_____

EMERGENCY INFORMATION

Parents' Names _________________________ Home Phone #___________________ Work Phone #_____________

Alternate Contact Person__________________ Home Phone # ___________________ Work Phone #_____________

ALLERGIES

Asthma Drug Allergies Food/Plant Allergies Hay Fever Insect Stings Other _______________________

____

MAJOR HEALTH PROBLEMS

Asthma Bleeding/Clotting Disorders Cardiac Diabetes Emotional Handicap ADD/ADHD

Epilepsy Nervous Disorder Physical Handicap Seizure Disorder Require Injections Other __________

If you have checked any of the above, please give details____

Activity Restrictions? ____

List any chronic or recurring illnesses or current medical conditions ____

Current Medications (name, date, drug & dosage) Send with instructions ______________________________________

Suggestions on health related information or special dietary needs____

This health information is correct so far as I know, and the person herein described has permission to engage in all prescribed activities as noted.

AUTHORIZATION FOR TREATMENT: In the event I cannot be reached in an emergency, I hereby give permission to medical personnel selected by Calvary Community Church to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. I hereby give permission to the physician selected by Calvary Community Church to secure and administer treatment, including hospitalization for the person named above. This form may be photocopied or digitized for trips away from the church.

Signature of Parent or Legal Guardian _____________________________________ Date _____________________

Parent's Full Name (print) ____