

**MEDICAL CONSENT FORM**

Please complete the following questions on any child under the age of 18. A minor might not be treated without this form.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_

Address \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Emergency Information:**

Parents/Guardians \_\_\_\_\_ Phone: \_\_\_\_\_ Bus: \_\_\_\_\_

Alternate Contact \_\_\_\_\_ Phone: \_\_\_\_\_ Bus: \_\_\_\_\_

Email \_\_\_\_\_

Youth Social Security # \_\_\_\_\_

If attempts to reach the above contacts are unsuccessful, please try to reach our pediatrician or physician:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health History: Allergies \_\_\_\_\_ Asthma \_\_\_\_\_ Insect Stings \_\_\_\_\_ Drug Allergies \_\_\_\_\_  
Hay Fever \_\_\_\_\_ Other \_\_\_\_\_

Specific instruction on allergies or medication: \_\_\_\_\_

**MAJOR PROBLEMS:**

Diabetes \_\_\_\_\_ Cardiac \_\_\_\_\_ Chronic Asthma \_\_\_\_\_ Nervous Disorder \_\_\_\_\_ Epilepsy \_\_\_\_\_

Physical Handicap \_\_\_\_\_ Emotional Handicap \_\_\_\_\_ Mental Handicap \_\_\_\_\_ Seizure Disorder \_\_\_\_\_

Other \_\_\_\_\_

If you have checked any of the above, please give details:

\_\_\_\_\_  
\_\_\_\_\_

Activity restrictions: \_\_\_\_\_

Date of last Tetanus Shot: \_\_\_\_\_

Insurance Info: Policy Holder: \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Policy Number: \_\_\_\_\_

This health history is correct, so far as I know, and the person herein described has permission to engage in all Church activities except as noted. In event I cannot be reached in an emergency during any Church activity, I hereby give my permission to the physician or dentist selected by the church sponsors, to hospitalize, to secure proper treatment and/or to order an injection, anesthesia or surgery for my child as deemed necessary. I also authorize the Church sponsors to administer medical aid as required for illness or injury under a physicians orders.

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ Date: \_\_\_\_\_