

Please print in ink

Name: _____ Age _____ Birthday _____
Last First Middle

Gender: M / F Email: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Cell: _____

Medical Insurance Company: _____ Policy #: _____

Emergency Contact: _____ Phone: _____ Work: _____

Physician: _____ Office Phone: _____

Dentist: _____ Office Phone: _____

MEDICAL HISTORY

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which you are subject and of which the staff should be aware, and what, if any action of protection is required on account thereof.

Checking the following areas of concern for this student. If necessary, add another page with details:

1. Medications currently taking: _____

2. Do you have allergies to:
____pollens ____medications ____food ____insect bites

3. Do you suffer from, or have you ever experienced, or are you being treated currently for any of the following:
____asthma ____epilepsy/seizure disorder ____heart trouble ____diabetes
____frequently upset stomach ____physical handicap

4. Date of last tetanus shot: _____

5. Other information regarding your health that a doctor should know:

For your information, we expect you to conform to these rules of conduct:

- No possession or use of alcohol, drugs, or tobacco
- No fighting, weapons, fireworks, lighters, or explosives
- No offensive or immodest clothing
- Respect property
- Respect students, staff, and other adult leaders
- Respect and comply with event schedules

Failure to comply with these expectations will result in you being asked to leave and may prevent future involvement in activities.

I have read and understand the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

Signature _____ Date: _____

This consent form gives permission to seek whatever medical attention is deemed necessary on my behalf, and releases the Church and its staff of any liability against personal losses.

I understand that there are inherent risks involved in any ministry or athletic event, and I hereby release the Church, its' pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my involvement. In the event that I am injured and require the attention of a doctor, I consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I also acknowledge that I will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I affirm that the health insurance information provided above is accurate at this date.

Signature: _____ Date: _____

Public Notary: _____ Date: _____

Notary Expiration: _____