COMMUNITY CHRISTIAN CHURCH
MEDICAL CONSENT FORM
410-933-8330

Medical Consent Forms are required to attend student activities. These forms are kept on file for one school year. A new Medical Consent Form is required at the beginning of each school year OR when a student's address, emergency contact, health and/or insurance information changes within the year.

Please Print

Name ____ Sex_______ Birth date _____/_____/______ Age______
Last First M.I

Address ____ Phone (____)____________ Grade________

City ____ State ________________ Zip ______________ Visitor Yes No

Emergency Information

Father's Name or Legal Guardian

____

Home Phone (_____)_________________

Work Phone (_____)__________________

Cell Phone (_____)___________________

Mother's Name or Legal Guardian

____

Home Phone (_____)______________________

Work Phone (_____)________________________

Cell Phone (_____)________________________

If Parents or Guardians are unavailable, call:

Alternate contact/Relationship: _______________________________________ Phone (____)______________________

HEALTH & INSURANCE INFORMATION

Do you carry family medical/hospital insurance? Yes No
If so, indicate Insurance Carrier____________________________________ Policy # ________________________________
Name of Family Physician _______________________________________ Phone (____) __________________________
Name of Family Dentist/Orthodontist ________________________________ Phone (____) __________________________

MAJOR MEDICAL PROBLEMS:

Allergies: Asthma Drug Allergies Hay Fever Insect Stings Other: ______________________________________
Asthma (chronic) Bleeding/Clotting Disorder Cardiac Diabetes Epilepsy
Emotional Disorder Nervous Disorder Physical Handicap Other: ____
If you have checked any of the above, please give details: ____
Activities restrictions? ____
Last operations or serious injuries with dates: ____
List any chronic recurring illness or medical condition: ____
Current medication: (send with instructions) ____
Date of last tetanus shot: (month/day/year) ______/______/_______

IMPORTANT: Please notify Community Christian Church (CCC) if your child has been exposed to a communicable disease within the last three weeks prior to the outing or event. This health information is correct so far as I know, and my son/daughter has permission to engage in all prescribed activities except as noted. I agree to update the above medical information regarding my son/daughter as is appropriate.

Authorization for treatment: I hereby give permission to the medical personnel selected by CCC to provide medical care in the best interest of my son/daughter in case of a medical emergency. In the event I cannot be reached in an emergency I hereby give permission to the physician selected by CCC to treat my son/daughter, including hospitalization, if necessary. This form, when complete, may be photocopied for trips away from CCC.

Signature of Parent or Legal Guardian: ____ Date: ______________