Youth
Browncroft Community Church
MEDICAL CONSENT FORM
2009-2010 SCHOOL YEAR

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

Address____ Phone (___) ______________ Grade _________

City____ State_________________ Zip _______ Visitor ☐Yes ☐No

EMERGENCY INFORMATION

Father's Name or Legal Guardian:
____

Home Phone (___)___________________
Work Phone (___)____________________
Cell Phone (___)______________
e-mail ____________________________

Mother's Name or Legal Guardian:
____

Home Phone (___)___________________
Work Phone (___)____________________
Cell Phone (___)______________
e-mail ____________________________

If Parents or Guardian 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 ☐Seizure Disorder Other ____________________________
If you have checked any of the above, please give details: ____
____
Activity restrictions? ____
List operations or serious injuries with dates: ____
List any chronic recurring illness of medical condition ____
Current medication: (send with instructions) ____
Date of last tetanus shot: (Month/day/year) ______/_____/_______

IMPORTANT: Please notify Browncroft Community Church (BCC) if your child has been exposed to a communicable disease within the three weeks prior to the outing or event. This health information is correct to the best of my knowledge, and my son/daughter has my 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 BCC 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 BCC to treat my son/daughter, including hospitalization, if necessary. This form, when complete, may be photocopied for trips away from BCC.
Permission to use photo:
____ I *grant* permission for my child's name/picture to be used in BCC publications/videos.
____ I *do not grant* permission for my child's name/picture to be used in BCC publications/videos.

Signature of Parent or Legal Guardian ____________________________________ Date: ________________