First Baptist Health Form

(Must be completed by parent or gardian)

Name: ______________________________ **Sex:** F__ M__ **Age:**_____
Date Of Birth: __________________
Address: ______________________________ **City:** ____________________
State: __________________ **Zip:** ________ **Phone:** ____________________

Part-1 Are there any health restrictions the church should be aware of?
Yes____ **No**____ If yes please explain:______________________________
Date of last physical examination:______________

Immunization Dates: Last Tetnus shot:__________ Tetnus Booster________ DPT series________
DPT Booster______ Polio______ Polio Booster_______

Health Concerns: (answer yes or no) Allergic to: Penicillin____ Sulfa____ Other Medicines____ Bee Stings____
Wasp Stings____ Other Insect Stings____ Poison Ivy____ Other Allergies______________

(answer yes or no) Subject To: Convulsions____ Asthma____ Skin Rash____ Fainting____
If yes Please explain:______________________________

Recent Surgery:______________________________
Recent exposure to communicable disease:______________________________
Heart disease:______________________________
Diet restrictions:______________________________
Information church should have (physical or mental limitations, behavioral disorders etc...)
Please explain:______________________________

Please note: **Church Staff cannot adminster Tylenol, Benadryl, Antacids, etc... without written permission from a parent or guardian. If your child needs to have any of these you must send them with your child. if they go on a trip.**

Part II Person to notify in case of emergency:______________________________
Relationship to:__________________ Home Phone:(_____)________________
Work Phone:(_____)________________ Cell Phone:(_____)________________
Doctor:______________________________ Phone:(_____)________________

Part III Health/Accident Insurance Company Name:______________________________
Policy Number:______________________ Group Number:______________________

PLEASE NOTE: THE FIRST BAPTIST INSURANCE POLICY STIPULATES THAT YOUR INSURANCE COMPANY WILL BE THE PRIMARY POLICY AND THAT THE CHURCH INSURANCE FOR ACCIDENTS WILL BE SECONDARY, COVERING THE COST THAT YOUR POLICY DOES NOT.

Part IV In case of accident or illness; I hereby authorize medical treatment and/or care of my child by a licensed physician or the hospital staff of any licensed hospital at the discretion of the CHURCH OR THE SPONSOR IN CHARGE OF THE ACTIVITY.

Signature:______________________________________ Date:____________
Relationship to Paticipant:______________________________