The Church of the Cross
Permission & Medical Information Form
2017-2018

Name_____ Age_____ Birthday_____

Male_____ Female_____ Email address_____

Address_____ City _____ State_____ Zip code_____

Home Phone _____ Cell Phone _____

Medical Insurance Company_____ Policy # _____

Emergency Contact _____ Relationship_____

Home Phone _____ Cell Phone _____

Physician _____ Office Phone _____

Dentist _____ Office Phone _____

I understand that there are inherent risks involved in any ministry or athletic event, and hereby release The church, its clergy, 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 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 and will, to the best of my knowledge, still be in force.

Student Signature_____ Date _____

Parent Signature _____ Date _____

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 student ministries staff of The Church of the Cross should be aware, and what, if any, action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names on medications and dosages that must be taken.

Check the following areas of concern. If necessary, add another page with details:

1. Do you have allergies to

-Pollens ____ -Medications ____ -Food ____ -Insect bites____

2. Do you suffer from or have you ever experienced any of the following:

-Asthma ____ Epilepsy/seizure disorder ____ -Heart trouble ____
Frequently upset stomach ____ -Physical handicap ____

3. Date of last tetanus shot: _____

4. Medicines being taken: _____

5. Please list and explain any major illness experienced during the last year:

_____

_____

_____

_____

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

_____

_____

_____

_____

7. AUTHORIZATION FOR MEDICAL TREATMENT

It is understood that this is authorization is given of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his authorized designee, in the exercise of his best judgment on what is advisable for my Childs care, upon advice of such physician, dentist, and surgeon.

Signature: _____ Date _____