

2017 Vacation Bible School  
Medical/Emergency Information

Person to contact in case of emergency:

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Other \_\_\_\_\_

Address \_\_\_\_\_

Family Doctor Name and Phone \_\_\_\_\_

Alternate contact:

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to child \_\_\_\_\_

Insurance Information:

Child is covered by a medical insurance policy: \_\_\_ Yes \_\_\_ No

Insurance Company \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Group Policy Number \_\_\_\_\_ Authorization Phone Number \_\_\_\_\_

I, the undersigned, hereby give permission for my son/daughter to participate in Vacation Bible School events and activities. I authorize any adult representative of Apostle Presbyterian, First United Methodist or Mount Hope Lutheran who is acting in a leadership role to consent to and authorize the administration and performance of all treatments that may be considered advisable or necessary in the judgment of attending physicians, in the event that the above named participant should be admitted to any hospital, or be in need of any medical treatment. I take full responsibility for all charges and fees related to treatment.

I understand that the care and safety of the participant will be primary in all planned activity and that all attempts will be made to contact parents/guardians prior to treatment if an emergency or accident should happen.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_