2018

LEXINGTON COMMUNITY CHURCH EMERGENCY CARE INFORMATION

In case of an emergency the Student Ministry staff will contact 911.
Every attempt will be made to contact a parent/guardian or a designated emergency contact.

STUDENT INFORMATION

Last Name:	Date of Birth:	School:
First:	Sex: Male, Female (circle one)	Grade:
Middle:	SSN:	

STUDENT RESIDES WITH: (circle one) FATHER, MOTHER, BOTH, LEGAL GUARDIAN

FATHER	ADDRESS	TELEPHONE
Last Name: _____	_____	Home (____) _____
First: _____	_____	Work (____) _____
Middle: _____	_____	Cell/Pager (____) _____
MOTHER	ADDRESS	TELEPHONE
Last Name: _____	_____	Home (____) _____
First: _____	_____	Work (____) _____
Middle: _____	_____	Cell/Pager (____) _____
LEGAL GUARDIAN	ADDRESS	TELEPHONE
Last Name: _____	_____	Home (____) _____
First: _____	_____	Work (____) _____
Middle: _____	_____	Cell/Pager (____) _____

LIST 2 PERSONS WE SHOULD CALL IN AN EMERGENCY IF THE PARENT(S) /GUARDIAN CANNOT BE REACHED

NAME OF PERSON	RELATIONSHIP	TELEPHONE
1._____		(_____) _____
2. _____		(_____) _____

INSURANCE INFORMATION

Name of Health Insurance Company: _____

Policy/Group/Employee Number: _____ HMO Number, if applicable: _____

Name of the Student's Physician: _____ Physician's Telephone: (_____) _____

MEDICAL INFORMATION

Check Any Current health Condition That May Require Attention During Student Ministry Outings.

___Allergies (be specific & include any food allergies/dietary restrictions)
Foods _____
Medicines _____
Bee Sting/Insect _____
Other _____
___Asthma
___Cancer
___Diabetes
___Hearing Problems ___Hearing Aid
___Seizures
___Hemophilia

LIST ALL MEDICATIONS AND DOSAGES YOUR CHILD RECEIVES ON A CONTINUAL BASIS:

_____
_____

FOR THE FOLLOWING, PLEASE BE SPECIFIC

___Heart Problems _____
_____

___Physical Disability _____
_____

___Respiratory _____
_____

___Vision Problems _____
___glasses ___contacts

__Other_____

Lexington Community Church has my permission, in an emergency when I (or my physician) cannot be contacted, to take my child to the emergency room of the nearest hospital. The hospital and its medical staff have my authorization to provide treatment which a physician deems necessary for the well-being of my child.

PARENT/GUARDIAN SIGNATURE: **DATE:**

RELEASE FORM 2018
LEXINGTON COMMUNITY CHURCH
LEXINGTON, ILLINOIS

1._____ ,

2._____ ,

3._____ ,

4._____ has my permission to attend and travel with the sponsors of Lexington Community Church. I transfer authority of my young person/people to the sponsors overseeing this youth function. In case of emergency, the sponsors have my permission to seek professional health care for my child or children.

_____
(parent or legal guardian)

Insurance Carrier: _____

Policy Number: _____

ID Number: _____

Phone Number: _____

Preferred Hospital: _____