MEDICAL INFORMATION FORM

FOR EMERGENCY TREATMENT OF CHILDREN AND YOUTH (AGE 18 AND YOUNGER) PARTICIPATING IN PROGRAMS OF

first baptist church MARTIN
WWW.FBCMARTIN.ORG
LIVE THE GREAT COMMANDMENT · FULFILL THE GREAT COMMISSION
123 University Street · P.O. Box 289 · Martin, TN · 38237

All information is confidential and will only be released to hospital or emergency room as needed

Full Name of Participant: _____

Participant's Social Security Number: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip_____

Name of Parent/Guardian: _____ Relationship to Participant: _____

Home Phone: _____Work Phone: _____ Cell Phone _____

As parent/legal guardian of _____, I do hereby authorize my consent to any X-ray, examination, anesthetic, medical or surgical diagnosis rendered under general or special supervision of any licensed medical staff member under the provision of the Medicine Practice Act. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, but is given to provide authority and power to render care which the aforementioned physician, in his or her best judgment, may deem advisable. It is understood that effort shall be made to contact me, the undersigned, prior to rendering treatment to my child, but that any of the above treatments will not be withheld if I cannot be reached. I agree to be responsible for paying any charges that may be incurred by such treatment. I hereby release First Baptist Church of Martin, Tennessee, its staff, and representatives, from any liability for accidents or injury sustained by my child in conjunction with any event.

Signature of Parent/Legal Guardian: _____ Date: _____

(Please sign this section in the presence of a Notary.)

MEDICAL INSURANCE INFORMATION (*required by all hospitals & emergency rooms*)

Insured Parent/Legal Guardian's Name: _____Date of Birth_____

Insured Parent/Legal Guardian's Work Place: _____ (Phone #) _____

Insured Parent/Legal Guardian's Social Security Number: _____

Insurance Company: _____ Phone: (____) _____

Group Number/ Policy Number: _____

Family Physician: _____ Dr.'s Phone Number: (____) _____

PARTICIPANT'S MEDICAL INFORMATION
(Use the back page if necessary.)

Date of last Tetanus or DPT immunization: _____

Any medications being taken: _____

_____

Allergies: _____

_____

List any other medical information or physical problems:

_____

_____

_____

_____

NOTARY ACKNOWLEDGMENT

Subscribed and sworn to before me, a Notary Public in and for Weakley County, Tennessee on this

_____ day of _____, 20____

_____
(Signature of Notary Public)

My Commission Expires

_____
(Date)