



The following health record must be filled out for each student by the parent or guardian, or the student cannot be a part of any Junior or Senior High Activity. Please print below. This release form will be kept on file.

Student Information

NAME _____ DATE OF BIRTH _____ MALE ☐ FEMALE ☐ AGE _____

PARENT/GUARDIAN NAME _____ PHONE _____

ADDRESS/CITY/STATE/ZIP _____

Medical History

List any medical Problems: _____

List any medications & dosage: _____

ALLERGIES (INCLUDE FOOD OR DRUG) _____

PAST SURGERIES _____

DATE OF TENANUS SHOT OR BOOSTER _____

Please circle any condition about the student that would be important for the physician to know about:
Allergy Asthma Diabetes Epilepsy Hearing Heart Vision Other

EXPLANATION OF OTHER _____

NOTE ANY HANDICAP _____

STUDENT'S DOCTORS' NAME _____ PHONE _____

Medical Insurance Information

INSURANCE COMPANY _____ PHONE _____

ADDRESS/CITY/STATE/ZIP _____

POL # _____ GROUP # _____ CARD HOLDER NAME _____

Emergency Contact Information: NAME _____ PHONE _____

Alternate Contact Information: NAME _____ PHONE _____

Treatment

In case of emergency, I hereby give permission to the physician selected by the Life Spring Church staff and or assigned personnel to hospitalize, secure treatment for, and to order injection, anesthesia and/or surgery for the student named above.

STUDENT SIGNATURE _____ NOTARY SEAL:

PARENT/LEGAL GAURDIAN SIGNATURE _____

NOTARY SIGNATURE _____ Date _____