

CITYREACH

Anaheim Omaha Arlington

www.gocityreach.com

CRAnaheim CROmaha

Medical Authorization

Name: _____ Age: _____ Grade: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Sponsor's Name: _____ Pastor's Name: _____

Attending Church Name: _____

In case of emergency, notify:

Name of Parent / Gaurdian: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Circle one: Home / Cell / Work

Secondary Phone: _____ Circle one: Home / Cell / Work

Secondary emergency contact:

Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Circle one: Home / Cell / Work

Secondary Phone: _____ Circle one: Home / Cell / Work

Will the camper be taking medication while at CityReach? Yes No

Medicine: _____ Dosage: _____ Time of Day: _____

Medicine: _____ Dosage: _____ Time of Day: _____

Permission to administer (check all that apply):

Tylenol Ibuprofen Benadryl Antacids Cold Medication Antibiotic Cream

CITYREACH

Anaheim Omaha Arlington

www.gocityreach.com

Major medical history (check all that apply):

Asthma Diabetes Kidney Trouble Heart Condition: _____

Dizziness Bronchitis Sinusitis Concussion Other: _____

Please list any allergies:

Has CityReacher recently been under a doctor's care? (explain):

Consent for Medical Treatment and Media Release

I give full permission for the above to attend CityReach and to take part in all activities. My child will not attend if he/she has been exposed to a contagious disease or if he/she is not in good physical condition. I do not hold CityReach Personnel and/or Sponsors responsible for any accident or illness; and if necessary, authorize CityReach Personnel and/or Sponsors to take my child to a physician or hospital. I also give my full consent for the doctor selected to render professional services to my child, if he/she becomes ill or is involved in an accident. As a parent/legal guardian, I give my permission for the above to be photographed and/or filmed during CityReach for the purpose of publications, multimedia, or website.

Charges for Insurance

Company Name: _____ Policy Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Have doctor bill me:

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Signature

Date