2018 YEAR MEDICAL CONSENT FORM

Rosemont Baptist Church Student Ministry

This medical consent form provides medical consent from January 1st 2018 through December 31st 2018.

Child's Full Name: _____
LAST FIRST MIDDLE

Gender: _____ Birthday: _____ Age: _____

Parent or Guardian Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

If not available in an emergency, notify:

Name: _____ Best Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Does this child have any allergies? _____

Does this child have any medical or health problems? _____

Is this child on any medications? _____ If so, what medications: _____

If so, will this child be bringing the medications they should be taking? _____

Describe any dietary restrictions that this child is required to observe: _____

State the name, address, medical specialty, and phone number of this child's physician who should be consulted in the event of emergency or medical problems involving this child:

Other comments from the parent or guardian concerning this child: _____

I understand that Rosemont Baptist Church carries medical and hospitalization insurance coverage which, consistent with the exclusions, limitations, and terms thereof, may provide over and above any personal medical and hospitalization coverages available to my family. I understand that any personal medical or hospitalization insurance available to my family will provide primary coverage and the church's policy will provide secondary or excess coverage.

I furthur understand that, in the event my child requires medical or dental treatment while engaged in the activity, reasonable efforts will be made to contact me; however, if I can not be reached, I hereby consent and give permission to the church's sponsor or any adult counsellor acting on behalf of the church with respect to the activity, as agent for me, to consent to any X-ray examination; injections; anesthesia; medical, dental, or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropiate) liscensed to practice undere the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medications being taken, medical problems and other pertintent information. My child has permission to participate in all prescibed activities except as noted by me.

Signature: _____ Date: _____
(Parent or Guardian)