2019 Health Form [CONFIDENTIAL]

Name: _____

Of Leonardtown Baptist Church

PLEASE PRINT

STUDENT INFORMATION

Date of Birth _____ Age _____ Sex ____

Address _____ City _____ State ___ Zip _____

Home Phone Number _____ Mobile Phone Number _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name(s) _____

[If Different] Address _____ City _____ State ___ Zip _____

Home Phone Number _____ Mobile Phone Number _____

EMERGENCY CONTACT (other than parent/guardian)

Name(s) _____ Home Phone _____ Mobile Phone _____

MEDICAL RELEASE STATEMENT

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during the activity, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that my insurance coverage for my child will be used as primary coverage in the event medical intervention is needed.

I understand all reasonable safety precautions will be taken at all times by the Youth Ministry Team of Leonardtown Baptist Church and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk.

I agree not to hold Leonardtown Baptist Church, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

I also give my authorization to give my child over-the-counter pain relief medication as needed and requested by him or her. My child may take the following type of pain relief medication: _____

Parent/Guardian Signature _____ **Date** _____

Signature of Student (if over 18 years of age) _____

If your child should require medical attention for injuries received or illnesses contracted prior to an activity, please send us the necessary information so that proper medical care may be given during his/her time with the Youth Ministry activity.

[PLEASE HAVE NOTARY FIX SEAL IN THE SPACE BELOW.]

State of _____
County of _____

On this _____ day of [month] _____, 20___, I hereby certify that the attached document is a true copy made by me from a record in my fair register of official acts.

In witness whereof I hereunto set my hand and official seal.

Signature _____

Notary Public _____

My commission expires on _____

HEALTH HISTORY

2019 Health Form [CONFIDENTIAL]

Name: _____

PLEASE PRINT

Pre-existing or present medical conditions:

_____

_____

_____

Name and dosage of any medications that must be taken:

_____

_____

Any allergies?

_____

Allergic to any medications?

_____

Please check any of the following to make us aware of your child's condition:

___ Hay Fever ___ Heart Condition ___ Diabetes ___ Epilepsy/Nervous Disorders

___ Asthma ___ Frequent Stomach Upsets ___ Physical Handicap ___ Major illnesses in the past yr?

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions)

_____

_____

_____

Date of Last Tetanus Shot _____ Contact Lenses? _____

Any swimming restrictions? Yes No What? _____

Any activity restrictions? Yes No What? _____

[PLEASE ATTACH PHOTOCOPY OF INSURANCE CARD TO THIS FORM.]