LivingWaters Church
MEDICAL CONSENT FORM

Please Print

Name: _______________________________ Sex: ____ Birth date: ______________ Age: ____
Last First
Address __________________________________ Phone (___)_____________ Grade: ______

City ___________________________________ State_____ Zip_______ Visitor: [ ]Yes [ ]No

EMERGENCY INFORMATION:

Father's Name or Legal Guardian:
____

Home Phone (____)___________________
Work Phone (____)____________________
Cell Phone (____)_____________________

Mother's Name or Legal Guardian:
____

Home Phone (____)________________
Work Phone (____)________________
Cell Phone (____)_________________

If Parents or Guardian are unavailable, call:

Alternate contact: _________________________________Phone (____)___________________

HEALTH & INSURANCE INFORMATION

Insurance Carrier ___________________________________Policy # _____________________
Name of Family Physician ____________________________Phone (____)_________________
Name of Family Dentist/Orthodontist _______________________Phone (____)____________

MAJOR MEDICAL PROBLEMS:
Allergies: [ ]Asthma [ ]Drug Allergies [ ]Hay Fever [ ]Insect Stings Other ___________
[ ]Asthma (chronic) [ ]Bleeding/Clotting Disorder [ ]Cardiac [ ]Diabetes [ ]Epilepsy
[ ]Emotional Disorder [ ]Nervous Disorder [ ]Physical Handicap [ ]Seizure Disorder
Other _____________________
If you checked any of the above, please give details:__________________________________
____
Activities restrictions?____
Current medication: (send with instructions)____

Authorization for treatment: I hereby give permission to the medical personnel selected by *living*WATERS Church to provide medical care in the best interest of my son/daughter in case of a medical emergency. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by *living*WATERS Church to treat my son/daughter, including hospitalization, if necessary.

Signature of Parent of Legal Guardian _______________________________Date __________