MEDICAL INFORMATION & AUTHORIZATION

Child's Name _____ Date of Birth _____

Father's Name _____ Occupation _____

Mother's Name _____ Occupation _____

Child's Address _____

Home Phone _____ Cell _____

Father's Work # _____ Mom's Work _____

Family Doctor _____ Office Phone _____

MEDICAL QUESTIONNAIRE

Is your child presently being treated for an injury or sickness or taking any form of medication for any reason? _____
_____

Is your child allergic to any type of medication? _____
_____

What is the date of your child's last Tetanus booster? _____

Does your child require a special diet? _____

Does your child have (or has ever had) any of the following: (Circle)

Seizure disorders	Asthma	Kidney disease
Heart disorders	Hay Fever	High blood pressure
Diabetes	Bronchitis	

Does your child have any allergies other than medical? _____

Does your child ever sleep walk? _____ Is your child a bed wetter? _____

Does your child get nervous or upset easily? _____

What is your child's swimming ability? None Poor Fair Good (Circle one)

Does your child have any physical handicap or illness, which would prevent him/her from participating in normal rigorous activity? _____
_____

If you have answered yes to any of these questions and need to explain in further detail, please do so on a separate sheet of paper.

MEDICAL TREATMENT AUTHORIZATION

_____ has permission to participate in any sanctioned youth or children's activities of Impact Family Church, including field trips, campouts, sporting events and any other normal activities.

I understand that I will be notified in the case of a medical emergency. However, in the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event my child is injured or becomes ill. I understand that the church will not be responsible for the medical expenses incurred, but that such expenses will be my responsibility as parent/guardian.

I agree to notify the church in the event of any health changes, which would restrict my child's participation in any normal youth or children's activities. I also understand the adult supervisors reserve the right to restrict my child from any activity that they do not feel is within the physical capabilities of my child.

In the event hospitalization is needed, please fill in:

Name of insured (policyholder) _____

Insurance Co. _____ Policy _____

Employer _____ Group No. _____

If you have no insurance, please give Credit Card Authorization:

Card No. _____ Type: Visa MasterCard Discover Amex

Expiration Date ___/___/___ Name as it appears on card _____

_____ _____

Signature of Parent/Guardian Date

Sworn and ascribed before me this _____ day of _____ in the year _____.

_____ is personally known to me, OR produced _____ as identification.

_____

(seal) Signature of Notary