

## MEDICAL RECORD FORM

Name \_\_\_\_\_ Age \_\_\_\_\_ M  F

Address \_\_\_\_\_ Birth Date \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Youth's Social Security Number \_\_\_\_\_

Parents' or Guardians' Name \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_

Parents' Telephone ( ) \_\_\_\_\_

Medical Insurance Company's Name \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder SSN \_\_\_\_\_

Family Doctor's Name \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

If parents are unavailable, the following individuals should be contacted:

1. \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

2. \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

### HEALTH INFORMATION

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Any restrictions while at youth events? If so, list \_\_\_\_\_

My child takes the following medication(s) daily, also list over-the-counter medications, e.g. Advil: \_\_\_\_\_

Date of last tetanus booster shot \_\_\_\_\_

Allergic Reactions: Bee Sting  Penicillin  Food  Other

Details of any of the above or additional information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

IN CASE OF MEDICAL EMERGENCY, I understand every effort will be made to contact parents or guardians. In the event I cannot be reached, I hereby give permission to the physician selected by the Pastor or volunteer leader to hospitalize, secure proper treatment for , and to order injection, anesthesia, or surgery for my child, as named above.

SIGNATURE

DATE

\_\_\_\_\_  
\_\_\_\_\_