Permission and Medical Consent
First Baptist Church of Lewisville, TX

Student's Full Name _____
Last First Middle

Gender (Male) (Female) Birthday _____ Age _____ School grade (2017-18) _____
month-day-year

Parent or Guardian Name _____

Home Address _____City _____State _____Zip _____

Home Phone _____Business Phone _____

Cell Phone _____

_____

Parent or Guardian Name _____

Home Address _____City _____State _____Zip _____

Home Phone _____Business Phone _____

Cell Phone _____

_____

If not available in an emergency, notify _____

Relationship to child _____

Home Address _____City _____ State _____Zip _____

Home Phone _____ Business Phone _____

Cell Phone_____

Does this student have any of the following allergies?

Penicillin _____ Other drugs _____

Insect Stings _____ Ivy poisoning, etc. _____

Hay Fever _____ Latex _____

Food Allergies? If so, what? _____

_____

Any other Allergies?, If so what? _____

_____

Over

Student's name _____

I give permission to administer over the counter medications

Advil/Motrin (ibuprofen) ***Yes*** _____ ***No*** _____ *Benadryl* ***Yes*** _____ ***No*** _____

Tylenol (acetaminophen) ***Yes*** _____ ***No*** _____ *Pepto-Bismol* ***Yes*** _____ ***No*** _____

Does this child have any medical or health problems/conditions, and or has this child had any chronic or recurring illness or illnesses: ***Yes*** _____ ***No*** _____ If yes, describe the problems or illnesses:

_____

_____

_____

_____

Child's family physician_____Phone number _____

Child's dentist (and orthodontist if applicable) _____ _____Phone number _____

Is this child currently taking medication ***Yes*** _____ ***No*** _____ If so, please state the medication

_____

_____

_____

If so, will this child be bringing the medication to the activity? ***Yes*** _____ ***No*** _____

If yes, please indicate the dosage prescribed, and the reason for the medication.

_____

_____

_____

Describe any dietary restrictions this child is required to follow:

_____

_____

_____

Date of child's last tetanus shot _____

Is there medical or hospitalization insurance which provides benefits for this child? ***Yes*** _____ ***No*** _____

If yes, please complete:

Name of insurance company_____

Address_____

Phone No. _____

Policy Holder's Full Name_____

Policy No. _____ Group No. _____

Other comments or suggestions concerning this child _____

_____

_____

I understand that, in the event my child requires medical or dental treatment while engaged in the activities either on or off campus at First Baptist Lewisville, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the ministry's sponsor, acting on behalf of the ministry with respect to the activity, as agent for me, to consent to any medical treatment deemed medically necessary, including but "not" limited to: x-ray examination; injection; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and given by a licensed physician, surgeon, dentist, or registered nurse, either as an outpatient or in a hospital. I further agree to indemnify and hold harmless any medical professional or church leader from loss, claim, or liability who provides authorization, medical, or first aid treatment to my child as deemed appropriate. I also give permission to the treatment facility to surrender physical custody of my child to the sponsoring agent's representative after treatment has been provided. To the best of my knowledge, I have disclosed and listed above all medical allergies, medication being taken, medical problems/conditions and pertinent information for the child indicated on this medical consent form.

Signature_____

(Parent or Guardian)

Print Full Name _____Date_____

November, 2017