

COMMUNITY CHRISTIAN CHURCH  
MEDICAL CONSENT FORM  
410-933-8330  
2010-2011 SCHOOL YEAR

*Medical Consent Forms are required to attend student activities. These forms are kept on file for one school year. A new Medical Consent Form is required at the beginning of each school year OR when a student's address, emergency contact, health and/or insurance information changes within the year.*

**Please Print**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Grade \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Visitor  yes  No

**Emergency Information**

Fathers Name or Legal Guardian \_\_\_\_\_

Mothers Name or Legal Guardian \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

**If Parents or Guardians are unavailable, call:**

Alternate contact/Relationship: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**HEALTH & INSURANCE INFORMATION**

Do you carry family medical/hospital insurance? Yes  No

If so, indicate 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 Other \_\_\_\_\_

If you have checked any of the above, please give details: \_\_\_\_\_

Activities restrictions? \_\_\_\_\_

Lost operations or serious injuries with dates: \_\_\_\_\_

List any chronic recurring illness or medical condition: \_\_\_\_\_

Current medication: (send with instructions) \_\_\_\_\_

Date of last tetanus shot: (month/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_

**IMPORTANT:** Please notify Community Christian Church (CCC) if your child has been exposed to a communicable disease within the last three weeks prior to the outing or event. This health information is correct so far as I know, and my son/daughter has permission to engage in all prescribed activities except as noted. I agree to update the above medical information regarding my son/daughter as is appropriate.

**Authorization for treatment:** I hereby give permission to the medical personnel selected by CCC 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 CCC to treat my son/daughter, including hospitalization, if necessary. This form, when complete, may be photocopied for trips away from CCC.

Signature of Parent or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_