bethany
come. consider. connect.

YEARLY MEDICAL INFORMATION FORM

August, 2015 August, 2016

PARTICIPANTS INFORMATION:

NAME: (First, Last) ______ BIRTHDATE: (MM / DD / YY) ___/___/___

ADDRESS: ______ CITY: ______ ZIP: ______

GENDER:	PROGRAMS ATTENDING (CHECK ALL THAT APPLY)	MEDICAL CONDITIONS / KNOW ALLERGIES (Especially to MEDICATIONS):
☐ MALE	☐ WEDNESDAY (BIA, GEMS, TEENS, Busy Bees)	______
☐ FEMALE	☐ SUNDAY (Kids Konnection, Sunday School, Toddlers)	______
	☐ OTHER: ______ (Over Nighters, Kids Camp, Outings, Childrens Chior)	DATE OF MOST RECENT TETANUS SHOT: ___/___/___

PARENT / LEGAL GUARDIAN INFORMATION:

NAME: (First, Last) ______ RELATIONSHIP: ______

ADDRESS: ______ CITY: ______ ZIP: ______

HOME PHONE: ( ) ______ CELL PHONE: ( ) ______ EMAIL ADDRESS: ______

Which Social Media sites are you on: ☐ Facebook ☐ Twitter ☐ Instagram

I prefer to receive info by: (NON EMERGENCY) ☐ Cell Phone ☐ Home Phone ☐ Text ☐ Email

MEDICAL INFORMATION:

PRIMARY MEDICAL INSURANCE COMPANY: ______ POLICY NUMBER: ______ GROUP OR TYPE NUMBER: ______

PRIMARY CARE PHYSICIAN'S NAME: ______ PHYSICIAN'S PHONE NUMBER: ( ) ______

OPTIONAL INFORMATION

DENTIST NAME: ______ DENTIST PHONE NUMBER: ( ) ______

ORTHODONTIST NAME: ______ ORTHODONTIST PHONE NUMBER: ( ) ______

EMERGENCY CONTACT INFORMATION:

IN THE EVENT OF AN EMERGENCY, CONTACTS WILL BE CALLED IN SUCCESIVE ORDER.

	NAME: (First, Last)	PHONE NUMBER:	RELATIONSHIP:
1		( )	
2		( )	
3		( )	

In my absence, I hereby give my consent and permission for medical transportation and to have a paramedic and/or duly licensed Doctor of Medicine and/or duly licensed Doctor of Dentistry provide my child or legal guardian, a minor identified as “Participants Name” above, with any and all medical assistance or treatment deemed necessary in the event of an accident, injury, or sudden illness. Further, I authorize admission to any hospital or medical facility for such treatment, including diagnostic procedures performed by licensed technicians or nurses. I authorize the hospital or medical facility to dispose of any specimens or tissue as appropriate. This release is effective until my arrival and it is revoked by me. I agree to be responsible financially for the cost of each transportation, assistance or treatment. I also give permission for my child or legal guardian, a minor identified as “Participants Name” above, to be photographed or videotaped during activities and allow Bethany to use these materials for public relations purposes.

The information contained in this form is valid for one year. If any information changes within time frame specified please contact the church office **IMMEDIATELY**.

SIGNATURE: PARENT / LEGAL GUARDIAN ______ DATE: ___/___/___