Calvary Chapel Santa Fe Springs
"Loving the Lost to Life"
12227 Florence Avenue • Santa Fe Springs,
California 90670
Phone 562-906-0697 • Fax 562-906-0117

MEDICAL HISTORY & RELEASE FORM

Child's Name _____ Age: _____ Gender: _____

Parent/Guardian Name: _____

Home Phone _____ Work _____ Cell: _____

Home Address _____

City _____ CA Zip _____

In Emergency, notify _____

Phone _____

Address _____

City _____ CA Zip _____

Relationship _____

Health History (Please last date as well)

Frequent Colds _____ Kidney Trouble _____ Chickenpox _____

Sinustis _____ Bedwetting _____ Measles _____

Mumps_____ Coughs _____ German Measles _____

Convulsions _____ Abscessed Ears _____ Athlete's Foot _____

Bronchitis _____ Sleepwalking _____ Whooping Cough _____

Fainting _____ Constipation _____ Polo _____

Nose Bleeds _____ Stomach Upsets _____ Rheumatic Fever _____

Tuberculosis _____ Serious Ivy, Oak or Sumac _____

Poisoning _____ Operation or Serious Injuries _____

Please explain

_____

Allergic Reactions: Bee Sting _____ Penicillin _____ Other Drugs _____

List all medications currently being taken: (include dosage)

_____

_____

List activities that are to be restricted, such as swimming, climbing, etc:

_____

_____

Medical & Liability Release Form

Should emergency medical treatment be necessary, I authorize Leadership or Overseers of **Calvary Chapel Santa Fe Springs** to act on my behalf and approve appropriate treatment. I also release from any and all liability of **Calvary Chapel Santa Fe Springs** and it's board as well as any of the church staff, board, and adult sponsors, in the event of any accident in route, during, and returning from this event.

I hereby give permission to the nurses or physician selected by the **Calvary Chapel Santa Fe Springs** Leadership or Overseers to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child named above as deemed necessary to avoid extreme or permanent physical damage or death.

Health Insurance Carrier

_____

Policy Number _____

Name of Insured_____

Copy of Medical Card attached _____ Yes

_____ _____

Parent/Guardian Signature Date