FAMILY MEDICAL FORM

HEALTH AND SAFETY INFORMATION FOR CLASSES, RETREATS, AND YOUTH GROUPS

information is confidential and will remain in the security of Faith Formation director in case of an emergency

INFORMATION BELOW REGARDING EMERGENCY CONTACTS RELATES TO ALL CHILDREN LISTED IN THIS MEDICAL FORM. YES ◯

Put contacts in descending order based on who should be called first to who would be called last in an emergency

PARENTAL GUARDIAN #1

PHONE NUMBER

PARENTAL GUARDIAN #2

PHONE NUMBER

EMERGENCY CONTACT IF PARENTS AREN'T AVAILABLE

PHONE NUMBER

RELATIONSHIP

EMERGENCY CONTACT 2 IF PARENTS AREN'T AVAILABLE

PHONE NUMBER

RELATIONSHIP

THE INFORMATION BELOW REGARDING MEDICAL COVERAGE RELATES TO ALL CHILDREN LISTED IN THIS MEDICAL FORM. YES ◯

COVERAGE/HEALTH CONTACT

INSURANCE COMPANY

PREFERRED PHYSICIAN

PHYSICIAN PHONE NUMBER:

HOSPITAL CHOICE ◯ ARNOT ◯ GUTHRIE ◯ OTHER

I GIVE PERMISSION FOR ALL MY CHILDREN'S PICTURE TO BE USED IN VARIOUS MEDIA (CHURCH BULLETIN, WEBSITE, NEWSPAPER) YES ◯ NO ◯

I hereby certify that the information in this form is correct and permits my children to be transported in privately owned vehicles in a medical emergency only, and for the release of medical records to an attending health care professional in case of illness. I understand every effort will be made to contact the parental guardians and listed contacts. If all contacts cannot be contacted, I hereby give permission for a qualified physician to secure proper treatment for my child.

CONSENT AND SIGNATURE

Guardian Signature Date:

Guardian Signature (revised year later) Date:

Guardian Signature (revised 2 years later) Date:

CHILD ONE: ELDEST CHILD

INFORMATION:

NAME

STREET ADDRESS

DATE OF BIRTH

CITY/STATE/ZIP

MEDICAL HISTORY

ALLERGIES YES NO

SPECIFY:

SPECIAL NEEDS/HEALTH CONCERNS (MEDICATIONS/DOSAGE OR DIETARY RESTRICTIONS):

OTHER CONCERNS REGARDING THEIR HEALTH AND SAFETY

CHILD TWO

INFORMATION:

NAME

STREET ADDRESS

DATE OF BIRTH

CITY/STATE/ZIP

MEDICAL HISTORY

ALLERGIES YES NO

SPECIFY:

SPECIAL NEEDS/HEALTH CONCERNS (MEDICATIONS/DOSAGE OR DIETARY RESTRICTIONS):

OTHER CONCERNS REGARDING THEIR HEALTH AND SAFETY

CHILD THREE

INFORMATION:

NAME

STREET ADDRESS

DATE OF BIRTH

CITY/STATE/ZIP

MEDICAL HISTORY

ALLERGIES YES NO

SPECIFY:

SPECIAL NEEDS/HEALTH CONCERNS (MEDICATIONS/DOSAGE OR DIETARY RESTRICTIONS):

OTHER CONCERNS REGARDING THEIR HEALTH AND SAFETY