Medical Information Form

North Central Baptist Church
8001 NW 23rd Ave. Gainesville, FL 32606

(Please type or print all information) Date:____/____/____

Student Information:

Name of student: ________________________________ D.O.B.: ____/____/____

S.S.#: ______/______/______ School: ________________________________ Grade: ________

Address: ____

Apt. #:_________________ City/State: _________________________ Zip: _________________

Home Phone: ______-______-______ Student's Cell (if applicable): ______-______-______

Email: ____

Parent/Guardian Information:

Mother's Name: __________________________________ Phone(s): Home ______-______-______

Place of Business: ____ Work ______-______-______

Email: ____ Cell ______-______-______

Father's Name: __________________________________ Phone(s): Home ______-______-______

Place of Business: ____ Work ______-______-______

Email: ____ Cell ______-______-______

Family member or friend to be contacted if parent(s)/guardian(s) cannot be reached:

Name: _______________________________________ Relationship: ____________________________

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell: _____-_____-_____

Medical Information:

Name of physician: ____ Phone: ______-______-______

Is your child covered by insurance? Yes No

Company Name: ____ Policy #: _____________________

Control Number or Treatment Number, if needed: ____

Does your child have a chronic illness? Yes No If yes, explain: ___________________________

____

Allergies? Yes No If yes, explain: ____

____

Allergic reaction to medication? Yes No If yes give name(s) of medication(s): ______________

____

Any physical restrictions which limit activity? Yes No If yes, what specific activities: _________

____

Any adverse reactions to anesthesia? Yes No If yes, explain: ___________________________

____

Any history of seizures? Yes No If yes, how often and what kind: ______________________

____

Are you presently taking any medication? Yes No If yes, what kinds: _________________

____

(Parent/Guardian must notify in writing, the name of the medication being used, dosage, how and when it is to be administered and then given to the assigned volunteer or minister prior to the event or departure. Your student will be responsible for taking their medication unless pre-arranged before the event)

Any history of diabetes? Yes No If yes, explain: _____________________________________

____

Date of the last tetanus shot: ____/____/____

Other helpful information: ____

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All information contained in this form will be treated as confidential and not shared unless necessary in providing care to your student.

Permission/Consent Form

North Central Baptist Church
8001 NW 23rd Ave. Gainesville, FL 32606

I, (we) ____, the undersigned parent(s) or

guardian(s) of ____________________________________ understand that sickness and/or accidents may occur while he/she is participating in activities sponsored by North Central Baptist Church. I realize that accidents, injury and/or sickness may occur during (but not limited to) routine or recreational activity, supervised or unsupervised activities and in such cases a representative of the church will notify me of the situation as soon as it is feasible to do so. I understand that this notification will be secondary to the security of the group and the welfare of my child.

In the event that my child experiences sickness or accident, I hereby grant permission to North Central Baptist Church and/or its representatives to seek medical and or dental care as deemed necessary by the adult acting on behalf of the ministry at the time of need. I also grant permission for my child to be examined and treated as deemed necessary by any physician, surgeon, dentist, emergency medical personnel, nurse, or others appropriately licensed for such treatment.

I further understand that while North Central Baptist Church carries insurance, I must first apply for benefits available through personal hospitalization and medical coverage before applying for benefits that may be available through the ministry's coverage. I understand that any personal coverage available to the participant will be the primary provider and the ministry's will be secondary.

I also understand that treatment and care for my child may include, but is not limited to: hospitalization, walk-in clinic care, x-rays, injections, anesthesia, prescribed medication, over the counter medicines, ambulance transport or emergency medical rescue. In the event that medical and/or dental treatment is needed, I agree to reimburse North Central Baptist Church for any expenses incurred while seeking service, doctors' fees, prescription drugs, over the counter medication, lodging due to illness, emergency room fees, walk-in clinic charges, long distance phone calls or transportation costs.

Every reasonable effort will be made to settle disciplinary problems in an accountable, productive and affirming manner. In the event, however, that my child impedes the direction and/or purpose of the event by his/her behavior and is sent home, it is my obligation to pay all cost related to his/her return. I also understand that an attempt will be made to notify me prior to an early departure and that reasonable effort will be taken to ensure a safe early return.

____ (Date): ______________________
(Adult Signature)

Notary

State of ____________________ County of _________________________

This instrument was
acknowledged before me on (Date) _____________________

Type of identification produced:

o Personally known

o Produced identification

____
(Signature of Notary)