First Christian Church

Medical Release and Insurance Information

Youth's Full Name: _____Date of Birth: _____

Social Security Number: _____ Age: _____

Address: _____ Home Phone: _____

City / Zip: _____ E-mail:_____

Name of School: _____ Grade: _____

Father's name: _____ Home Phone: _____

Occupation: _____ Work Phone: _____

Cell Phone: _____

Mother's name: _____ Home Phone: _____

Occupation: _____ Work Phone: _____

Cell Phone: _____

Person to contact if parent(s) is/are unavailable:

Name & relation: _____ Home Phone: _____

Occupation: _____ Work Phone: _____

Cell Phone: _____

Physician's Name: _____ Phone: _____

Please list any recurring health problems: (i.e. stomach aches, ear infections):

_____

Are immunizations up to date? _____ If no, please explain _____

Date of last Tetanus Shot: _____

Any activity limitations? _____ Do you wear contacts? _____

Any specific activities to be encouraged? _____

Any specific activities to be restricted? _____

List any medications or drugs taken regularly: _____

Any special medical or dietary regime to be continued? _____

First Christian Church

Medical Release and Insurance Information

Form is valid for one year

Name of Youth: _____
Insurance issued in the name of: _____
Medical/Health Insurance Co. Name: _____
Subscriber ID: _____ **Group Number:** _____
Preauthorization Phone # _____

I certify that the above-named youth is my child or my legal ward and resides with me. In the event he/she becomes ill, is injured, or for any reason requires medical treatment while attending a function or activity, I do hereby consent to any and all medical or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physician selected by agents or officials of the First Christian Church of Dyersburg, TN. In the event treatment is called for which a physician or other health care provider refuses to administer without my/our consent, I/we hereby authorize the Staff at First Christian Church of Dyersburg, TN or any other representatives of First Christian Church of Dyersburg, TN. to give such consent and further agree to hold any person harmless from any claims, demands, or suits of any nature arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician. I further authorize the release of the listed medical information to appropriate medical personnel and/or the health coverage insurance company. I will notify the church if I feel there are any health considerations that would prevent my child's participation in any activity. I also give my permission for leaders to restrict my child from participation in any activities that they have any questions about for health or other reasons.
The intention of this release is to grant authority to administer and perform any and all examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. I will see that payment is made for all medical expenses incurred for medical treatment for the above named youth. This payment will be made by myself or by my insurance company providing coverage for the above-named youth.
As the parent (or legal guardian), I the undersigned, certify that my child, named above, has my express permission to participate in all activities, of any nature, sponsored by First Christian Church of Dyersburg, TN. from the date received. I fully release First Christian Church of Dyersburg, TN, its authorized representatives and staff from all liability of any kind and character upon any claim, demand, or cause of action that might be asserted in our behalf against said church, representatives or staff.

I _____ understand and agree to abide with the restrictions placed on my activities by my parent/guardian.

Signature of Youth:_____ Date _____

Signature of Parent/Guardian: _____ Date _____

Sworn to and subscribed before this _____ day of _____ .
NOTARY PUBLIC
State of Tennessee, My commission expires:
_____
PRINT, TYPE OR STAMP
COMMISSIONED NAME OF NOTARY PUBLIC
Personally known_____ or _____Produced Identification (list type)

*****Please include a copy of your insurance card, front and back, with this Medical Information Form*****