

Adult Medical Consent Form 2021
First Baptist Church of Lewisville

Name _____

Birth date _____

Home phone _____ Cell phone _____

Home address _____

City _____ Zip _____

Emergency contact name _____

Relationship to sponsor _____

Home phone _____ Cell phone _____

Home address _____

City _____ Zip _____

If not available in an emergency, notify _____

Relationship to sponsor _____

Home address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Any of the following allergies?

Latex **Yes** _____ **No** _____

Penicillin **Yes** _____ **No** _____

Insect Stings **Yes** _____ **No** _____

Ivy Poisoning **Yes** _____ **No** _____

Other Drugs **Yes** _____ **No** _____

Other Allergies _____

Allergies to animals/pets _____

Please list any other food or non food allergies (peanuts, milk etc:)

Do you have any medical or health problems/conditions, and or have you any type of chronic or recurring illnesses:
Yes ____ No ____ If yes, please describe :

Name of family physician _____

Phone number _____

Are you currently taking medication **Yes** ____ **No** ____ If so, please state the medication

If so, will you be bringing the medication to the activity? **Yes** ____ **No** ____

If yes, please indicate the dosage prescribed, and the reason for the medication.

Date of last tetanus shot _____

Is there medical or hospitalization insurance which provides benefits to you? **Yes** ____ **No** ____

If yes, please complete:

Name of Insurance Company _____

Address _____

Phone No. _____

Policy Holder's Full Name _____

Policy No. _____ Group No. _____

I understand that, in the event I require medical or dental treatment while engaged in the activities either on or off campus at First Baptist Lewisville reasonable efforts will be made to reach the emergency contact. However, if I am not able to verbally give my consent and the emergency contact cannot be reached, I hereby consent and give permission to the ministry's sponsor, acting on behalf of the ministry with respect to the activity, as agent for me, to consent to any medical treatment deemed medically necessary, including but "not" limited to: x-ray examination; injection; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and given by a licensed physician, surgeon, dentist, or registered nurse, either as an outpatient or in a hospital. I further agree to indemnify and hold harmless any medical professional or church leader from loss, claim, or liability who provides authorization, medical, or first aid treatment to myself as deemed appropriate. To the best of medical problems/conditions and pertinent information for myself indicated on this medical consent form.

Signature _____

Print Full Name _____ Date _____