

Student's Full Name \_\_\_\_\_  
Last First Middle

Gender (Male) (Female) Birthday \_\_\_\_\_ Age \_\_\_\_\_ School grade (2022-23) \_\_\_\_\_  
month-day-year

Parent or Guardian Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Parent or Guardian Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

If not available in an emergency, notify \_\_\_\_\_

Relationship to child \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Does this student have any of the following allergies?

Penicillin \_\_\_\_\_ Other drugs \_\_\_\_\_

Insect Stings \_\_\_\_\_ Ivy poisoning, etc. \_\_\_\_\_

Hay Fever \_\_\_\_\_ Latex \_\_\_\_\_

Food Allergies? If so, what? \_\_\_\_\_

Pet Allergies, what kind? \_\_\_\_\_

Any other Allergies?, If so what? \_\_\_\_\_

Student's name \_\_\_\_\_

I give permission to administer over the counter medications

Advil/Motrin (ibuprofen)	<b>Yes</b>	<b>No</b>	Benadryl	<b>Yes</b>	<b>No</b>
Tylenol (acetaminophen)	<b>Yes</b>	<b>No</b>	Pepto-Bismol	<b>Yes</b>	<b>No</b>

Does this child have any medical or health problems/conditions, and or has this child had any chronic or recurring illness or illnesses: **Yes** **No** If yes, describe the problems or illnesses:

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Child's family physician \_\_\_\_\_ Phone number \_\_\_\_\_

Child's dentist (and orthodontist if applicable) \_\_\_\_\_ Phone number \_\_\_\_\_

Is this child currently taking medication **Yes** **No** If so, please state the medication \_\_\_\_\_

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If so, will this child be bringing the medication to the activity? **Yes** **No**

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

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Describe any dietary restrictions this child is required to follow:

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Date of child's last tetanus shot \_\_\_\_\_

Is there medical or hospitalization insurance which provides benefits for this child? **Yes** **No**

If yes, please complete:

Name of insurance company \_\_\_\_\_

Address \_\_\_\_\_

Phone No. \_\_\_\_\_

Policy Holder's Full Name \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Other comments or suggestions concerning this child \_\_\_\_\_

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I understand that, in the event my child requires medical or dental treatment while engaged in the activities either on or off campus at First Baptist Lewisville, reasonable efforts will be made to contact me; however, if I 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 my child as deemed appropriate. I also give permission to the treatment facility to surrender physical custody of my child to the sponsoring agent's representative after treatment has been provided. To the best of my knowledge, I have disclosed and listed above all medical allergies, medication being taken, medical problems/conditions and pertinent information for the child indicated on this medical consent form.

Signature \_\_\_\_\_

Parent or Guardian - Student and parent if student is 18 or over

Print Full Name \_\_\_\_\_ Date \_\_\_\_\_