Fredericksburg Baptist Church

Children/Youth Medical Consent Form

Child's Full Name: _____ Age: _____
Last First Middle

Gender: _____ Birthday: _____ SSN: _____

Parent or Guardian Name(s): _____

Home Address: _____

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

If not available in an emergency, please notify:

Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

This child has the following allergies:

_____

_____

_____

This child has the following medical or health problems:

_____

_____

_____

This child is on the following medications: _____

Date of last Tetanus shot: _____

The name, address, medical specialty and phone number of this child's family physician and of any other physician who should be consulted in the event of emergency or medical problems involving this child:

_____

_____

The name, address and phone number of this child's dentist (and orthodontist if applicable):

_____

_____

Hospitalization insurance which provides benefits for this child:

Name of Insurance Co. _____ Policy No. _____

Address: _____

Name of Policy Holder: _____ Group No. _____

Phone: _____

I, (parent's name, please print) _____ , give FBC the absolute right and permission to use my child's photograph(s) in its promotional materials and publicity efforts. I understand that the photographs may be used in a publication, print ads, electronic media (e.g., video, Internet, etc.), or other forms of promotion. I understand that my child's name and/or address will not be published in any form.

Parent/Guardian accepting Signature: _____ Date: _____

I, (parent's name, please print) _____ , decline the photo release.

Parent/Guardian declining Signature: _____ Date: _____

I understand that, in the event my child requires medical or dental treatment while engaged in a FBC activity, reasonable efforts will be made to contact me; however, if I cannot be reached, I herby consent and give permission to the ministry's sponsor or any adult counsellor acting on behalf of the ministry with respect to the activity, as agent for me, to consent to any X-ray examination; injections; anesthesia, medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medications being take, medical problems and other pertinent information.

Parent/Guardian Signature: _____ Date: _____

Print Full Name: _____