



Faith Church Medical Info/Release Form



Child: _____ Date of Birth: _____

PARENT/GUARDIAN AUTHORIZATION

Family Physician: _____ Phone: _____

In case of emergency contact:

Name, Phone (including cell phone if you have) Relationship to child

Name, Phone (including cell phone if you have) Relationship to child

Medical Insurance Company: _____

Policy Number: _____ Group Number: _____

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder). The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

If your child is on any medication, who will administer the meds during FMAC events?

CHILD or a FAITH YOUTH SPONSOR **(please circle one)**

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

Print Parent/Guardian Name

Authorized Parent/Guardian Signature