Health Information Form

Name of Student: _____ Date of Birth: _____

Address: _____ Age: _____ Gender: _____

City: _____ State: _____ Zip Code: _____

Phone Number:_____

Emergency Contact Person:

Parent/Guardian Name: _____

Address (if different from student): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Alternate Contact Person: (Use someone near the primary contact)

Name: _____

Address: _____ Age: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell:_____ Work: _____

PARENT MEDICAL AND LIABILITY RELEASE STATEMENT:

I understand that if medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form in the event I cannot be reached in an emergency. I hereby give my permission to the attending physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that my insurance coverage for my child will be used as primary coverage in the event medical treatment is needed.

I understand all reasonable safety precautions will be taken by ***Freedom Hill Community Church*** and its agents during the events and activities. I understand the possibility of ***unforeseen*** hazards and know the inherent possibility of risk. I agree ***not to*** hold ***Freedom Hill Community Church***, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form. **This form is effective beginning September 1, 2019 and ending August 31, 2020.**

Parent or Guardian Signature: _____

Date: _____

PLEASE COMPLETE THE OTHER SIDE

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity.

Do you have health insurance? □ Yes □ No

Name of Insurance Company (if applicable): _____

Policy/Group Number: _____

In whose name is the insurance? _____

Family Doctor: _____ City: _____

Doctor's Phone Number: _____

Health History:

Pre-existing or present medical conditions:_____

_____

Name and dosage of any medications that must be taken:_____

_____

_____

Allergies (include allergies to medications): _____

_____

Any major illnesses during the past year? _____

_____

Date of Last Tetanus Shot: _____ Contact Lenses? □ Yes □ No

Any activity restrictions? _____

_____

_____