PLEASE ATTACH A COPY OF YOUR CURRENT INSURANCE CARD (FRONT & BACK) TO THIS FORM

CHILDREN/YOUTH MEDICAL RELEASE

FIRST BAPTIST CHURCH OF ELLISVILLE

Name ______________________________ D.O.B. _______ Age_____Grade ______ Sex____

Address ____________________________ City _________________ State ____ Zip _______

Father _________________ Cell ______________Work ___________ Home ______________

Mother _________________ Cell ______________Work ___________ Home _____________

Other person to contact in case of emergency : ___________________________________

Home_____________________ Cell ____________________ Work ______________________

DATE OF LAST TETANUS SHOT __________________

HEALTH HISTORY - Check if child has had:

___ ear infections ___dietary restrictions ___chicken pox ___measles
___ heart trouble ___operations ___ allergies ___ serious health issues

ALLERGIES - Check if child is allergic to:

___ insect stings ___ penicillin ___ foods ___other drugs
___ poison ivy ___ other

If child has allergies to other drugs or foods, please list them and their reaction.

____

____

List medications child is currently taking, including vitamins. Please indicate the dosing instructions for each medication.

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Please list the name, address and phone number of the child's physician and any physician who should be consulted in the event of an emergency or medical problem.

Physician	Address	Phone
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________

Please list the name, address and phone number of your child's dentist and/or orthodontist. ____

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Please provide information concerning any insurance benefits for which your child is eligible:

Insurance Company ____________________ **Insured's Name** __________________________

Policy Number ______________________________ **Group Number**_____________________

Phone Number of Insurance Company ____

AUTHORIZATION FOR EMERGENCY CARE

In the event of an emergency or if I cannot be reached, I give permission to the physician(s) selected by the First Baptist Church of Ellisville leaders to order x-rays, tests, injections, surgeries, anesthesia or other treatment deemed necessary for the health of my child. I understand that I will be financially responsible for the cost of any medical treatment and ambulance or other transportation expense for my child. FBC Ellisville has insurance coverage which may provide benefits over and above personal coverage.

Although I recognize that circumstances such as time and distance may affect the choice of a medical facility, I prefer that my child be treated at the hospital(s) that I have placed a checkmark by: __ St. Luke's West __ St. John's Mercy Hospital __ Missouri Baptist __ Cardinal Glennon __ Children's Hospital __ St. Joseph

________________________ **has my permission to attend any official, scheduled on-site or off-site First Baptist Church of Ellisville activity from January 1, 2009 through December 31, 2009.**

________________ ______________________________

Date **Signature**

____

Notary
Notary Public-State of Missouri
County of St. Louis
My commission expires __________