



**MEDICAL CONSENT FORM**

CHILD'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

PARENT/GUARDIAN NAME(S): \_\_\_\_\_  
First Name(s) Last Name(s)

PARENT/GUARDIAN CONTACT NUMBERS: \_\_\_\_\_ Cell \_\_\_\_\_  
 \_\_\_\_\_ Home \_\_\_\_\_  
 \_\_\_\_\_ Work \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_  
First & Last Name Relationship

EMERGENCY CONTACT PHONE: \_\_\_\_\_  
Please include area code

**MEDICAL INFORMATION**

Is your child presently being treated for an injury or sickness or taking any form of medication for any reason?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Is your child allergic to any type of medication?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Does your child have any allergies other than medicine?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Does your child have/had any of the following?  
 Hay Fever  Heart Murmur  Kidney Disease  Seizures  Diabetes  Asthma  
 If yes, please explain: \_\_\_\_\_

Does your child require a special diet?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Does your child sleep walk?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Does your child know how to swim?  Yes  No  
 Can he/she swim in water over his/her head?  Yes  No



Does your child have any special needs or physical/mental/social challenges that we should be aware of or that would hinder his/her ability to participate in normal rigorous activity?  Yes  No

If yes, please explain:

**CONSENT AND CERTIFICATION**

This form will be kept at the church office for future reference if needed. This Medical form is to be completed once each year (Sept. – Sept.). Please contact the church office if you need to update your information.

Being the parent or legal guardian of the above named child, I am willingly completing this form, providing all information needed to The Mission Church in case an emergency happens during any activity or event. This form will stay in effect for one year from the date of submission unless The Mission Church is notified, in writing, by the parent/guardian.

**MEDICAL TREATMENT AUTHORITY**

I (we) authorize The Mission Church staff, in whose care the minor has been entrusted, to consent to an x-ray examination, anesthetic, medical, surgical care, dental diagnosis and hospital care, to be rendered to the minor under their general or special supervision and on the advice of any physician or dentist or hospital or medical staff of a hospital, whether such diagnosis or treatment is rendered at the office of the said physician or dentist or hospital. We (I) hereby release The Mission Church, its directors, members and employees from all liability and claims arising out of the said diagnosis and or treatment, and hospital care, to be rendered to the minor by the aforesaid physician, dentist or licensed hospital. The parent and or guardian shall be liable and agree (s) to pay costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization. Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs. The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in children’s activities sponsored by The Mission Church.

INSURANCE COMPANY: \_\_\_\_\_  
 POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_  
 NAME OF POLICY HOLDER: \_\_\_\_\_  
 SIGNATURE OF PARENT(S): \_\_\_\_\_  
 DATE: \_\_\_\_\_