

2016-2017

## Medical Consent Form

The purpose of this form is to guarantee the protection and welfare of the Jr. and Sr. High students of Grace Church. Please complete the following questions on any student that will be involved in activities this year.

### Personal History

Name: \_\_\_\_\_  Male  Female  
Mailing Address: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Primary Guardian (check one):  Father  Mother  Relative  Stepparent  
\_\_\_\_\_ Home Phone: \_\_\_\_\_  
\_\_\_\_\_ Work: \_\_\_\_\_  
Secondary Guardian (check one):  Father  Mother  Relative  Stepparent  
\_\_\_\_\_ Home Phone: \_\_\_\_\_  
\_\_\_\_\_ Work: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### Emergency

If attempts to reach the above contacts are unsuccessful, please try to reach our family doctor or dentist.

Family Doctor: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Dentist: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
Home Phone: \_\_\_\_\_

### Health History

Please check box(es) that apply and give specific details below if special treatment is necessary:

Allergies  Asthma  Insect Stings  Hay Fever  Special Diet Requirement  
 Glasses/Contacts  Regular Medication  Drug Allergies

Major Problems:

Diabetes  Epilepsy  Seizure  Mental Handicap  Cardiac  
 Attention Deficit/Hyperactivity Disorder  Injuries \_\_\_\_\_

\_\_\_\_\_

Other Health History Details: \_\_\_\_\_

\_\_\_\_\_

# Other Information

Please use the following space to share any other information pertinent to your student's health or behavior. List any special instructions or information we would need to know in order to care for your student's basic needs:

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## Authorization for Administration of Over the Counter Medications

- I DO NOT give permission for my child to receive medications
- I give permission for my child to receive medication(s) listed below (check all that apply)
- Ibuprofen (Motrin, Advil)    Acetaminophen (Tylenol)
- Tolnaftate 1% or Clotrimazole 1% (Antifungal Cream)    Triple Antibiotic Ointment
- Diphenhydramine (Benadryl)    Benzocaine (Orajel)    Cough Drop
- Anesthetic Ointment/Spray

# Insurance

Should our child require medical treatment while participating in a Grace Church event our own family medical insurance is the primary carrier and will be billed first:

Policyholder: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Insurance Agent: \_\_\_\_\_

Pre-Certification #: \_\_\_\_\_

Office Phone: \_\_\_\_\_

# Consent Agreement

I/We, the undersigned, parent(s) of \_\_\_\_\_, in case of an emergency, authorize the adult leaders of Grace Church to secure proper treatment for my/our child in case of emergency. It is understood that my/our authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, and is given to provide authority and power on the part of the Grace Church adult leaders to give emergency medical treatment if necessary. It is also understood that every effort will be made to contact the primary and secondary guardian (or emergency contact) in case of such an emergency or accident, if possible, before any such medical treatment is administered.

Signature: \_\_\_\_\_ (Primary/Secondary Guardian)

Date: \_\_\_\_\_