# 2018-2019
# 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:

_____

_____

### 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) ☐Triple Antibiotic Ointment
☐Tolnaftate 1% or Clotrimazole 1% (Antifungal Cream) ☐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: _____**