NORTHERN HILLS UNITED METHODIST CHURCH 2021

THIS FORM MAY BE PHOTOCOPIED WHEN COMPLETED. PRINT CLEARLY. USE BLACK INK.

NAME____________________________ __________________________ ____________ ______________________________

Last First Middle Home phone

ADDRESS_________________________________ **CITY**______________________ **ZIP**________________

____/___/ ___ ___________ ______________________________

Date of Birth Grade School

____ ______________________________________

Child's Doctor /Clinic Doctor's Phone

Date of Last: Health Exam __________ ___________T.B. test

SHOT RECORD: _______Hepatitis A ________Hepatitis B ________Tetanus Shot

____ ____________________________ _________________________________

Father's Name Work Phone Cell Phone

____ ____________________________ _________________________________

Mother's Name Work Phone Cell Phone

____ ____________________________ __________________ ______________

Alternate Emergency Contact Name Day Phone Evening Phone Relationship

HEALTH HISTORY: (CHECK THOSE THAT APPLY)

DRUG ALLERGIES: ____

____

OTHER ALLERGIES: ____Animals ___Food ___Insect stings ___Plants ___Pollen ____ Other

If any checked please explain: ____

____

CHRONIC OR RECURRING ILLNESS:

___Ear infections ___Contact lens wearer ___Heart defect/disease ___Seizures ___Bleeding disorder

___ Asthma ___Diabetes ___Other (specify) ____

____

SURGERIES, INJURIES OR OTHER HEALTH ISSUES: ____

____

IN THE LAST YEAR: (ANSWER YES OR NO)

Have you been out of the USA in the last year? _______

Complicating medical problems/operations? _______ Serious injury/illness requiring medical care? _________

Please explain: ____

____

SPECIFIC INSTRUCTIONS CONCERNING MY CHILD'S CARE: ____

____

____

____

HOSPITAL INSURANCE INFORMATION: ** Please attach photocopy of insurance card*

Name of Carrier Policy Number Group Number

Insured's Name

Company Name (if insured through employer)

FAMILY MEMBER (S) WHO MAY BE CONTACTED IN CASE OF EMERGENCY TO AUTHORIZE TREATMENTS:

Name Day Phone Evening Phone Relationship

Name Day Phone Evening Phone Relationship

MEDICAL TREATMENT AUTHORIZATION

I (we) understand that in the event the child named above is injured while in the care of Northern Hills United Methodist Church and requires the attention of a doctor, the Director of Children's Ministries, and/or representatives of Northern Hills United Methodist Church will make every effort to contact us. If I (we) cannot be reached by telephone at one of the numbers listed above, or if because of an emergency, there is not time or opportunity to make a telephone call, I (we) hereby authorize the Director of Children's Ministries, and/or representatives of Northern Hills United Methodist Church to give consent on my (our) behalf for emergency medical treatment. In the event that it becomes necessary for a representative of Northern Hills United Methodist Church to give consent on our behalf they are authorized:

1. To have access to any and all medical and related information and records.
2. To disclose medical and related information to others.
3. To employ and discharge medical and related personnel.
4. To consent or refuse consent to medical care and emergency medical procedures.
5. To provide appropriate relief from pain.
6. To arrange for care and lodging in a hospital.
7. To grant releases to health care professionals or institutions to assure that the wishes of the parent/guardian are fulfilled.
8. To take immediate physical custody and possession of the child that is the subject of this authorization in the absence of the ability of the parent/guardian to do so, and to provide for the care and physical custody thereof during such absence.

Parent Signature Date