# STUDENT MEDICAL CONSENT FORM
(please complete both pages and submit to New Hope Church)

Student's Full Name _____
Last First Middle

Gender ____ Birthday _____ Age_____ Grade_____

Parent or Guardian Name(s)_____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____
Cell Phone _____

If not available in an emergency, notify:
Name_____ Phone_____
Street Address_____ City_____ State____ Zip_____

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Does this student have any of the following allergies:
Penicillin_____ Other_____
Other drugs_____ What Type_____ _____
Insect Stings_____ What Type_____ _____
Food_____ What Type_____ _____
Ivy Poisoning, etc._____
Hay Fever_____ Date of last Tetanus shot_____

Does this student have any medical or health problems, and has this student had any chronic or recurring illness or illnesses, which would have an effect on the student's participation in any activity?
( ) Yes ( ) No
If yes, describe the problem or illness_____
_____
_____

Are there any activities, such as strenuous activities, to be restricted for this student? _____ If so, describe: _____
_____

Is this student on any medication? _____ If so, please state the medication_____
Will this student be bringing this medication to any activities offered by the church? _____
Other comments or suggestions concerning this student. _____
_____
_____

Primary care physician: _____ Name of dentist: _____
Street Address _____ _____
State_____ Zip _____ _____ _____
Phone _____ _____

Is there medical or hospitalization insurance which provides benefits for this child? _____ If so, please indicate:

Name of Policy Holder _____

Name of Insurance Co. _____

Street Address _____

State _____ Zip _____ Phone _____

Insurance Policy Number _____

I understand that, in the event my child requires medical or dental treatment while engaged in an event or activity, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give my permission to the church's sponsor or any adult counselor acting on behalf of the ministry with respect to the event or activity, as agent for me, to consent to any hospital care and treatment advised and supervised by a physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all my child's medical allergies, medications being taken, medical problems and other pertinent information. My child has permission to participate in all activities except as noted by me.

I CERTIFY THAT I HAVE READ THIS DOCUMENT, AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

Signature_____ Date _____
Parent or Guardian

Witness_____ Date _____