

Personal Information

Date Filed: _____

Full Name: _____

Home Address: _____

Telephone #: _____ () _____ Email: _____

Emergency Contact Name: _____

Emergency Contact #: Home: (if different from above #) _____ () _____

Work: _____ () _____

Cell / Mobile: _____ () _____

Birthdate: ____ / ____ / ____

Medical Information

****PLEASE FILL OUT BELOW or ATTACH A COPY OF CURRENT INSURANCE CARD**

**Medical ID # _____

**Name of Insured (Parental Provider): _____

**Insurance Carrier: _____

**Insurance Address: _____

**Insurance Customer Service Phone #: _____ () _____

Specific Allergies to medications or otherwise: _____

Blood-type (if known): _____

Special Medical conditions: _____

Other important information: _____

I, the undersigned do hereby authorize Stockbridge Community Church of God, Inc., organization or Counselors / Chaperones, the adult leaders in whose care the said is entrusted as agents for the undersigned, do consent to any emergency treatment, X-ray examination, anesthetic, medical, surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act.

PARENT/LEGAL GUARDIAN

DATE

This form will be kept on file for the term of 1 (one) year from signed date.