CONFIDENTIAL

MEDICAL CONSENT/WAIVER

To Whom It May Concern:

The undersigned does hereby give permission for our (my) child,_____
(Name of child)
to attend and participate in activities sponsored by FIRST ALLIANCE CHURCH, 2201 Old Higbee Mill Rd, Lexington, KY 40514.

Child's Full Name *(Please Print)* _____
Sex_____ Birthday_____
Social Security Number_____

Parent or Guardian Name *(Please Print)*_____
Street Address _____
City_____ State_____ Zip_____
Home Phone (___)_____ Business Phone (___)_____

If not available in an emergency, notify:
1. Name_____ Phone (___)_____
   Street Address_____ City_____ State_____
   Relationship to Child (friend, grandparent, etc.) _____

OR
2. Name_____ Phone (___)_____
   Street Address_____ City_____ State_____
   Relationship to Child (friend, grandparent, etc.) _____

Does this child have any of the following allergies?
( ) Penicillin ( ) Insect Stings ( ) Hay Fever
( ) Other Drugs_____ ( ) Ivy Poisoning, etc. ( ) Other
(Explain on back)

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

Indicate the date of this child's last tetanus shot _____
Are there any activities such as strenuous activities, to be restricted for this child? ( ) Yes ( ) No
*If yes, describe:*_____

Is this child on any medications? ( ) Yes ( ) No *If yes, please state medication:*_____

Describe any dietary restrictions that this child is required to observe_____
_____

State the name, address, medical specialty and phone number of this child's family physician and of any other physician who should be consulted in the event of emergency or medical problems involving this child:_____
_____

State the name, address, and phone number of this child's dentist *(and orthodontist if applicable):*
_____
_____

(over, please)

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

Name of Insurance Company_____

Address_____

Phone No. of Insurance Company (____)_____

Policy No. of Insurance Policy_____

Name of Policy Holder_____

Other comments or suggestions from the parent or guardian concerning this child _____

_____

_____

We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by FIRST ALLIANCE CHURCH.

To the best of my knowledge, I have listed above all of my child's medical allergies, medications being taken, medical problems and other pertinent information. My child has permission to participate in all the prescribed activities except as noted by me. Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

Signature_____ Date_____

(Parent or Guardian)

Print Full Name_____ Date_____