2018-2019

Allergies? Yes____ No _____
Describe below

CONFIDENTIAL

MEDICAL CONSENT/WAIVER

The undersigned does hereby give permission for our (my) 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_____

Parent or Guardian Name *(Please Print)*_____
Street Address _____
City_____ State_____ Zip_____
Phone (____) -_____ Alternate 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 allergies? Please list
_____
_____
_____

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:*_____
_____
If so, will this child be bringing medications that he/she will be taking to the activity… ( ) Yes ( ) No

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

State the name, address, and phone number of this child's Pediatrician/Family Physician or 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):*
_____
_____

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 _____

_____

_____

I understand that, in the event my child requires medical or dental treatment while engaged in the Activity, reasonable efforts will be made to contact me; however, if I cannot be reached, I authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, injections, anesthetic, medical, surgical or dental diagnosis and treatment, and 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 of my child's medical allergies, medications being taken, medical problems and other pertinent information. My child has permission to participate in all 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.

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.

Signature _____ Date _____

(Parent or Guardian)

Print Full Name _____ Date _____