

Luke 4:18 Fellowship Health Form

This form must be completed by the parent/guardian.

PARTICIPANT _____ BIRTHDATE _____ AGE _____ SEX _____
PARENT/GUARDIAN _____ RELATIONSHIP _____
HOME ADDRESS _____ CITY _____ ZIP _____
HOME PHONE _____ WORK PHONE _____

IF NOT AVAILABLE FOR AN EMERGENCY, NOTIFY:

NAME _____ RELATIONSHIP _____ PHONE _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ ID NUMBER _____
INSURANCE ADDRESS: _____ CITY _____ ZIP _____
NAME OF POLICY HOLDER _____

IMPORTANT: NO PARTICIPANT UNDER 18 YEARS OF AGE WILL BE ALLOWED TO PARTICIPATE UNLESS THIS BOX IS FULLY COMPLETED.

AUTHORIZATION FOR MEDICAL TREATMENT

The undersigned parent/guardian/person authorizes the Youth Director of the Luke 4:18 Fellowship or one of its agents to secure medical treatment for _____ in case of any illness or accident for which the Youth Director or first aid personnel feels professional medical attention is required. I hereby give permission to the physician selected to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for me/my child as named.

Signature of Parent/Guardian or Participant if of legal age

Relationship

Date

I understand that the above signature authorizes the Youth Director of Luke 4:18 Fellowship acting through its appointed Coordinator to secure medical treatment for me.

Luke 4:18 Fellowship Participant Signature

Date

Family Physician _____ Number _____

HEALTH INFORMATION

Allergies _____

Eyes- () Normal () Glasses () Contacts Ears -() Normal () Hearing Aid () Hard of Hearing

Medications (Please list all prescribed and over the counter) _____

Are you sending the medication _____ Date of last Tetanus booster _____

Specific Medical History _____

Special Diet _____

I give permission for this form to be used for all 2019 Events

Parent's Signature