

**STUDENT INFORMATION &  
MEDICAL AUTHORIZATION FORM**



First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Grade Last Completed: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

In case of Emergency Please Contact:

1) \_\_\_\_\_  
*Name Phone Relationship*

2) \_\_\_\_\_  
*Name Phone Relationship*

Will you be taking any medicine? If yes, please complete the following:

\_\_\_\_\_ *Medicine, dosage, time of day*

\_\_\_\_\_ *Medicine, dosage, time of day*

\_\_\_\_\_ *Medicine dosage, time of day*

<b>INSURANCE INFORMATION:</b>
<i>Name of Insurance</i> Amanda Parrish
<i>Cardholder's Name</i>
<i>Policy #</i>
<i>Group #</i>

<b>CHURCH INFORMATION</b>
<b>Spring Creek Baptist Church</b>
<i>Name of Church</i>
<b>Dr. Terry B. Parrish</b>
<i>Pastor's Name</i>
<b>Brotherhood Mutual</b>
<i>Name of Church's Insurance</i>
<b>03M0430298</b>
<i>Policy #</i>
<b>Ministry First</b>
<i>Group #</i>
<b>309 Insurance Dr</b>
<i>Address of Insurance Company</i>
<b>Fort Wayne, IN 46825</b>
<i>City, State, Zip</i>

Please explain if a) you have recently been under a doctor's care for medical reasons, or b) there are any allergies or special health problems which we should know about.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT:** I give my full permission for my son/daughter/legal ward to attend Spring Creek Youth Activities and church camp, and to take part in all activities. He/She will not attend if he/she has been exposed to a contagious disease, or if he/she is not in good physical condition. I do not hold church personnel, camp personnel, or sponsor responsible for any accident or illness and, if necessary, authorize church personnel, camp personnel, or sponsors to take my child to a medical facility. I also give my full consent for the medical facility selected to render professional services to my child if he/she becomes ill or is involved in an accident.

Signed by Parent or Guardian \_\_\_\_\_

Print Name \_\_\_\_\_

Date: \_\_\_\_\_