

EMERGENCY MEDICAL FORM OF A MINOR

Youth's Name: _____

Phone Number: _____

Youth's Birthdate: _____

Social Security Number: _____

Youth's Address: _____

In an emergency, parent(s) or other contact can be reached as follows:

Name (Parent): _____

Name (Relationship): _____

Phone #: _____

Phone #: _____

Cell Phone #: _____

Cell Phone #: _____

Youth's Medical History:

Allergies, if any, including medication:

Chronic or existing diseases or medical problems: (I.e. Diabetes, Epilepsy, etc.)

Medicines your youth is currently taking and instructions:

(MUST BE GIVEN TO PASTOR GREG OR TANIS FOR DURATION OF ACTIVITY)

Over the counter medicines that may be given to your youth: (I.e. Tylenol, cough drops, Benadryl)

IF IT IS NOT LISTED HERE WE ARE NOT ALLOWED BY LAW TO GIVE IT TO THEM WHATEVER THE SITUATION.

Medical Information:

Family Doctor: _____

Phone: _____

Medical Insurance Carrier: _____

Medical Insurance ID#: _____

Member's Name: _____

Insurance Benefit Code #: _____

Signature of Parent or Guardian: _____

Date: _____