

Lone Oak First Baptist Church

2017 Parental Consent/Medical Treatment Form

PERSONAL INFORMATION

(Please **print** the following information)

Participant Name _____ () Male () Female Student Cell:(____)_____

Address _____ City _____ St _____ Zip _____
Student

Date of Birth ___/___/___ Age _____ Grade _____ Email: _____

Twitter: _____ Instagram: _____

Mom Name _____ Dad Name _____

(Secondary Address)

Address _____ City _____ St _____ Zip _____

Home: _____ Work: (____) _____ Cell:(____) _____ Cell: (____) _____

Resides With: () Mom () Dad () Both () Guardian T-shirt size: _____

Primary Email: _____ Secondary Email: _____

MEDICAL INFO

In case of emergency notify: _____ Contact Number: (____) _____

Insurance Company or Group: _____ Policy Number _____

Physician Name _____ Phone: (____) _____

List all medications currently taken: _____

Allergies, medical problems or other pertinent information: _____

MEDICAL TREATMENT

I, the undersigned parent or guardian, in the event medical treatment is required and I cannot be reached, give my permission to Lone Oak First Baptist Church Student Ministry or an adult sponsor to secure the services of a licensed physician to provide the care necessary, including anesthesia or surgical diagnosis/treatment, for my child's well-being. I agree to be responsible for the costs and expenses incurred in connection with such medical services rendered to my child pursuant to this authorization, and will not hold Lone Oak First Baptist Church liable.

Signature: _____ Relationship to Student: _____ Date: _____