LONE OAK
FIRSTBAPTISTCHURCH
Real People Serving the Real God

2017 – 2018 Parental Consent / Medical Treatment Form

Today's Date: _____

(Please PRINT the following information)

Participant's Information

Participant's Full Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Grade: _____ ☐ Male ☐ Female T-shirt Size: _____

Address: _____ City: _____ State: _____ Zip: _____

Participant's Cell Phone: _____ Participant's Email: _____

Twitter: _____ Instagram: _____

Parent (Legal Guardian) Information

Resides with: ☐ Mom and Dad ☐ Mom ☐ Dad ☐ Guardian: _____

Mother's Name: _____ Father's Name: _____

Mother's Cell Number: _____ Father's Cell Number: _____

Home Phone Number: _____ Alternative Phone Number: _____

Primary Email: _____ Secondary Email: _____

Address: _____ City: _____ State: _____ Zip: _____
(if different than above)

Medical Contact Information

In case of Emergency Contact: _____ Contact Number: _____

Insurance Company or Group: _____ Policy Number: _____

Physician's Name: _____ Contact Number: _____

Medical Information

List <u>all</u> medications *currently* taking:

Allergies, Medical Concerns, or other pertinent information: (please include what to do in case of allergic reaction)

Medical Treatment Consent

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.

Printed Name: _____ Signature: _____ Date: _____

Relationship to Student: ☐ Mother ☐ Father ☐ Guardian - Relationship: _____