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_______

Date of Birth ____/____/____ Age________ Grade __________ Student Email: ______________________________

Twitter: ___________________________________Instagram: _______________________________________

Mom Name _________________________________ Dad Name ______________________________________

(Secondary Address)

Address____ City ____________ St _____ Zip_______

Home: ______________ Work: (____) _____________ Mom Cell:(____) ____________ Dad Cell: (____) _____________

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

Primary Email: ______________________________ Secondary Email: ______________________________

MEDICAL INFORMATION

In case of emergency notify: _________________________________ Contact Number: (____) _____________

Insurance Company or Group:________________________________ Policy Number ___________________

Physician Name ____ Phone: (_____) ____________________

List all medications currently taken: ____

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Allergies, medical problems or other pertinent information: ____

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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: _____________