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: ______ School: ______________________________ ☐ 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 all 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: ______________________________