

**Student Medical Information**  
**First United Methodist Church**  
Pensacola, FL

**Effective dates: June 1, 2011 to June 1, 2012**

Student's Full Name \_\_\_\_\_  
Social Security No. \_\_\_\_\_  
Address \_\_\_\_\_  
City/Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_  
Boy ( ) Girl ( ) Age \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Email \_\_\_\_\_

Name of School \_\_\_\_\_

Grade \_\_\_\_\_

Father's name \_\_\_\_\_  
Email \_\_\_\_\_

Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Mother's Name \_\_\_\_\_  
Email \_\_\_\_\_

Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Person to contact if parent(s) is/are unavailable:  
Name and relation \_\_\_\_\_  
Email \_\_\_\_\_

Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Physicians Name \_\_\_\_\_

Phone: \_\_\_\_\_

HEALTH HISTORY (Check all that apply)

	<u>DISEASES:</u>	<u>ALLERGIES:</u>
Frequent ear infections _____	Chicken pox _____	Penicillin _____
Frequent Colds/Sore Throats _____	Measles _____	Aspirin _____
Sinusitis/Bronchitis _____	Mumps _____	Other _____
Strep Throat _____	German Measles _____	Food _____
Mononucleosis _____	Whooping Cough _____	Insect Stings _____
Heart Defect/Disease _____	Tuberculosis _____	Poison Ivy/Oak/Sumac _____
Epilepsy/Convulsions _____	Polio _____	Hay Fever, etc. _____
Bleeding/Clotting Disorders _____	Diabetes _____	SUBJECT TO: Sleep Walking _____
Hypertension _____	Asthma _____	Fainting _____ Bedwetting _____
Stomach Problems _____	Arthritis _____	Constipation _____ Other _____

Other Diseases or Details of Above \_\_\_\_\_  
\_\_\_\_\_

Are immunizations up to date? \_\_\_\_\_ If no, please explain \_\_\_\_\_

Date of last Tetanus Shot \_\_\_\_\_ Date of last TB skin test \_\_\_\_\_

Activity limitations? \_\_\_\_\_ Do you wear contacts? \_\_\_\_\_

Specific activities to be encouraged? \_\_\_\_\_

Specific activities to be restricted? \_\_\_\_\_

List any medications or drugs taken regularly \_\_\_\_\_

Special medical or dietary regime to be continued? \_\_\_\_\_

Suggestions for Chaperones or Church Leaders \_\_\_\_\_  
\_\_\_\_\_

**Medical Release & Insurance Information**  
**Valid June 1, 2011 to June 1, 2012**

Name of Student \_\_\_\_\_

Insurance issued in the name of \_\_\_\_\_ Is coverage for dependents? \_\_\_\_\_

Medical/Health Insurance Co. Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Preauthorization Phone # \_\_\_\_\_

I certify that the above-named student is my child or my legal ward and resides with me. In the event he/she becomes ill, is injured, or for any reason requires medical treatment while attending a First United Methodist church function or activity, I do hereby consent to any and all medical or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physician selected by agents or officials of the First United Methodist Church. In the event treatment is called for which a physician or other health care provider refuses to administer without my/our consent, I/we hereby authorize the Staff at First United Methodist Church or any other representatives of First United Methodist Church, to give such consent and further agree to hold any person harmless from any claims, demands, or suits of any nature arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician.

I further authorize the release of the listed medical information to appropriate medical personnel and/or the health coverage insurance company. I will notify the church if I feel there are any health considerations that would prevent my child's participation in any activity. I also give my permission for leaders to restrict my child from participation in any activities that they have any questions about for health or other reasons.

The intention of this release is to grant authority to administer and perform any and all examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. I will see that payment is made for all medical expenses incurred for medical treatment for the above named student. This payment will be made by myself or by my insurance company providing coverage for the above-named student.

As the parent (or legal guardian), I the undersigned, certify that my child, named above, has my express permission to participate in all activities, of any nature, sponsored by First United Methodist Church for the 2011-2012 calendar year. I fully release First United Methodist Church, its authorized representatives and staff from all liability of any kind and character upon any claim, demand, or cause of action that might be asserted in our behalf against said church, representatives or staff.

In addition, I also give authorization for First United Methodist Church to use my child's first name, voice, likeness, photograph and video in program materials, promotional materials, and other works such as publications, video commercials and internet display.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date** \_\_\_\_\_

Notarized:

State of Florida, County of Escambia

Sworn to and subscribed before me the \_\_\_\_\_ day of \_\_\_\_\_,

by \_\_\_\_\_

who is ( ) personally known or ( ) produced \_\_\_\_\_ as identification.

\_\_\_\_\_  
Signature/Name of Notary