

**CROSSROADS COMMUNITY CHURCH  
MEDICAL CONSENT FORM  
(661-313-8300)**

Please Print

NAME \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_ Grade \_\_\_\_\_

**EMERGENCY INFORMATION:**

Father's Name or Legal Guardian: \_\_\_\_\_

Mother's Name or Legal Guardian \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_  
Pager (\_\_\_\_) \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_  
Work Phone(\_\_\_\_) \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_  
Pager (\_\_\_\_) \_\_\_\_\_

**IF PARENTS ARE UNAVAILABLE, CALL:**

Alternate Contact/Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**HEALTH & INSURANCE POLICY INFORMATION**

Do you carry family medical/hospital insurance? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, Indicate Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Name of Family Dentist/Orthodontist \_\_\_\_\_ Phone #(\_\_\_\_) \_\_\_\_\_

**MAJOR MEDICAL PROBLEMS:**

Allergies: Asthma \_\_\_ Drug Allergies \_\_\_ Hay Fever \_\_\_ Insect Stings \_\_\_ Other \_\_\_\_\_

Asthma(chronic) \_\_\_ Bleeding/Clotting Disorder \_\_\_ Cardiac \_\_\_ Diabetes \_\_\_ Epilepsy \_\_\_

Emotional Disorder \_\_\_ Nervous Disorder \_\_\_ Physical Handicap \_\_\_ Seizure Disorder \_\_\_

Other \_\_\_\_\_

If you have checked any of the above please give details. \_\_\_\_\_

Activity restrictions? \_\_\_\_\_

List of operations or serious injuries with dates: \_\_\_\_\_

List any chronic, recurring illness or medical condition: \_\_\_\_\_

Current medication: (send with instructions) \_\_\_\_\_

Date of last tetanus shot: (mo/day/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_

**IMPORTANT:** Please notify Crossroads Community Church (CCC) if your child has been exposed to a communicable disease within the three weeks prior to the outing or event. This health information is correct so far as I know, and the person described has my permission to engage in all prescribed activities except as noted. **AUTHORIZATION FOR TREATMENT:** I here give permission to the medical personnel selected by CCC to order X-rays, routine tests, and treatments; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency I hereby give permission to the physician selected by CCC to secure and administer treatment, including hospitalization, ambulance transport and paramedics for the person named above. I hereby agree to fully pay all costs of medical or dental care incurred by CCC or their agent for the child under this authorization. Pictures may be taken during the event for church use. This form, when completed, may be photocopied.

Signature of Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_