

MEDICAL ALERT-TREATMENT/EVENT/PHOTO-VIDEO RELEASE FORM May 2018-May 2019

**YOU MUST FILL THIS OUT COMPLETELY-PLEASE PRINT IN INK.
INDICATE "Non-Applicable" WHEN NECESSARY AND SIGN THE THREE PLACES ON BACK!**

STUDENT MINISTRY OF FIRST BAPTIST CHURCH MURPHY, TX

Name of Student: _____ **Year of Graduation** _____ **Gender: M / F** **Date of Birth:** ___/___/___
Legal Guardian: _____ **Relationship:** _____
_____ **Address:** _____ **City:** Murphy/ Other
_____ **State TX** **Zip** _____ **Phone #'s:** _____

Business _____ **Cell/Other** _____ If we cannot reach parent(s), my child may be entrusted to the following people. (Please list two: other than person listed above)

1. Name _____ (relationship) _____
Phone _____
Name _____ (relationship) _____ Phone _____

Physician's Name _____ **Phone** _____
Address _____ **City** _____ **State** _____ **Zip** _____

Insurance Company _____ **Policy#** _____ **Group#** _____
****Please attach a copy of the front and back of your insurance card.**

Person Responsible for Payment: _____ **SS#** _____
Phone _____ **Address** _____
City _____ **State** _____ **Zip** _____

Immunizations: (year) Tetanus ___ Polio ___ Measles ___ Mumps ___ Other _____

PAST MEDICAL HISTORY

Indicate all childhood diseases: Chicken Pox ___ MMR ___ Whooping Cough ___
Indicate all the following illnesses, diseases, or medical conditions the student has or has had:
___ Asthma ___ Bronchitis ___ Chronic upset stomach ___ Heart Condition ___ Seizures
___ ADHD ___ Hyperactivity ___ Diabetes ___ Hemophilia ___ Hepatitis ___ Kidney Conditions ___ Dizziness ___ Colitis
___ Depression ___ Epilepsy ___ Sinusitis ___ ADD ___ Other _____

List any family/hereditary illness or medical conditions _____

Previous operations/critical surgical procedures and the results _____

ALLERGIES:

History of anesthesia reactions (self or family)? ___ Yes ___ No If yes, please explain _____
Allergic to any of the following medications? ___ Yes ___ No If yes, which one(s):
___ Aspirin ___ Codeine ___ Morphine ___ Penicillin ___ Sulfa ___ Other _____
Food Allergies _____

CURRENT MEDICINES:

List all medications you are currently taking on a regular basis: _____

SPECIAL DIET? Please list name and content:

