CHRIST CONGREGATIONAL CHURCH, UCC
MEDICAL FORM

Name: ____ DOB: ____________________
Address: __________________________________ E-Mail: __________________________
Parent/Guardian: ____
Phone: ___________________ (H) ___________________ (W) _____________________ (Cell)
Name of School Attending in the Fall ____

Emergency Contact in event cannot reach above: ____
Telephone(s): ____________________ _____________________ ____________________
Relationship to child: ____

Health Insurance Provider: _________________________________ Phone:________________
Primary subscriber named on policy: ____
Policy #: _________________________________ Group #: ____________________________

Physician's Name: _______________________________________ Phone: ________________
Physician office address: ____

Medical Information

Date of last physical exam: ____________________ Date of last tetanus booster: _____________
All vaccinations/immunizations are current. ___Yes ____No
If no, please list: ____

Allergies (foods, insects, environments, medicine, etc.): ____________________________________
____

*Current prescription medication: ____
*Current over the counter medication: ____________________________________

Must complete medication permission form on backside of this sheet.

Child currently under medical or psychiatric care. ____Yes _____ No
If yes, please explain: ____
____

Are there any restrictions that limit his/her activity? ____ Yes _____ No
If yes, please explain: ____
____

I give my permission for my child to attend and participate in all phases of this program, including fieldtrips if applicable. I will not allow my child to attend if he/she becomes exposed to any contagious disease, or if for any reason, I do not consider him/her to be in good physical condition. I give my permission for my child to receive necessary medical attention at a hospital, clinic, or from a designated adult supervisor.

Parent/Guardian Signature: ______________________________ **Date:** ________________

Revised 4/24/08

MEDICAL PERMISSION

My child, ________________________, takes the medications listed on this form. The designated Christ Congregational Church adult leader of this program/activity has my permission to administer the listed medication(s) to my child as directed by me.

Medication: ____
Purpose: ________________________________ Dosage: _________ Frequency: __________

Taken _____ orally _____ topical _____ nasal _____with meals _____empty stomach
Comments:

Note any reaction or side effects:

Prescribed by physician: __________________________ Office Number ( ) _______________

Medication: ____
Purpose: ________________________________ Dosage: _________ Frequency: __________

Taken _____ orally _____ topical _____ nasal _____with meals _____empty stomach
Comments:

Note any reaction or side effects:

Prescribed by physician: __________________________ Office Number ( ) _______________

Medication: ____
Purpose: ________________________________ Dosage: _________ Frequency: __________

Taken _____ orally _____ topical _____ nasal _____with meals _____empty stomach
Comments:

Note any reaction or side effects:

Prescribed by physician: __________________________ Office Number ( ) _______________