

CREEKSIDE COMMUNITY CHURCH MEDICAL HISTORY & EMERGENCY RELEASE FORM

Student's name(s): _____ Parent/Guardian name: _____

Home address: _____ Home phone: _____

MEDICAL INFORMATION:

Is the student under the care of a physician for an illness at this time? Yes _____ No _____

If so, illness: _____

Is the student taking medication at this time on a continual basis? Yes _____ No _____

If so, list medication: _____ Dosage: _____

Is the student allergic to or made sick by penicillin, aspirin, codeine or any other drugs or medication?
(This includes itching, rash, swelling or hands, feet, or eyes) Yes _____ No _____

List & name: _____

Does the student have any allergies to bee stings, food allergies, or any other allergies we should be aware of? Yes _____ No _____ Please list: _____

IN CASE OF EMERGENCY PLEASE CONTACT: _____ PHONE: _____

Family Physician: _____ Phone: _____

Please list two other responsible persons to contact in case of emergency:

Name: _____ Phone: _____

Name: _____ Phone: _____

INSURANCE INFORMATION:

Insurance Company Name: _____

Name in which insurance is listed: _____

Policy # _____ ID # _____