EMERGENCY MEDICAL INFORMATION

(One per child)

Name ____________________________________ Birthday __________ Age _______

Address ________________________________ City _________________ Zip _______

Home Phone ____________________ Parent's Cell/Office ________________________

Other emergency telephone numbers ____

Doctor's Name ________________________ Office Phone _______________________

Insurance Provider______________________ Policy #___________________________

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CONFINDENTIAL HEALTH HISTORY

HAS HE/SHE HAD:	YES	NO		YES	NO
Appendicitis			Heart ailments		
Asthma			Scarlet fever		
Hay fever			Hernia		
Rheumatic fever			Poliomyelitis		
Diabetes			Epilepsy		
Fainting spells					
Does he/she have or has he/she had any contagious diseases?					
Other significant injury or operation?					
Is he/she taking any medication?					
Are his/her activities restricted for any reason?					
Is he/she allergic to penicillin or other medications?					

Please explain fully if you marked YES to any above: ______________________________

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PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In the event my son/daughter becomes ill or sustains injury while in the care of or under the supervision of a representative of Living Word Christian Center, they are given permission to administer first aid for his/her relief. Consent is also given to admit him/her to any hospital and for all medical, surgical, diagnostic and hospital procedures or treatment as may be performed or prescribed, including the administration of such drugs or medicines, by a physician for him/her when such treatment is deemed immediately necessary or advisably to safeguard my child's health and it is not advisable or practical to return him/her to us or to receive our instruction for his/her care. I/we waive my/our right to informed consent for said treatment.

DATE ________________ SIGNATURE ____

(Parent or Guardian)