HEALTH FORM FOR *2015-2016* SCHOOL YEAR

First United Methodist Church
Albany, Georgia
Health and Medical Information

PLEASE USE BLACK INK.
PLEASE PRINT.

Name: _____ Address: _____
Age: ____ Current Grade: ____ Sex: ____ Date of Birth: _____ Home Phone #:_____

Mother's Name: _____ Address: _____
Mother's Phone # (Home):_____ (Office):_____ (Cell):_____
Mother's Email Address: _____

Father's Name: _____Address:_____
Father's Phone # (Home):_____ (Office):_____ (Cell):_____
Father's Email Address:_____
Emergency Name (other than parent):_____Phone #:_____

Insurance Information

Subscriber Name (Name in whom insurance is listed):_____
Insurance Carrier:_____Group Name (Employer):_____
Insurance #:_____Address for claims to be mailed: _____
_____
If possible, please attach a copy of your insurance card.

Medical Information

Drug /Food Allergies: _____
Medications taken on a **regular basis**: _____
Medical Conditions: _____
Physician's Name: _____ Phone #:_____
Date of last Tetanus Booster: _____

Parents will be contacted immediately if medical treatment is necessary. I hereby give permission for the counselors of First United Methodist Church, Albany, Georgia, to consent for medical treatment by physician or hospital on the above said minor child.

_____ _____
Parent/Guardian Signature Date

Additional comments: _____
_____
_____

Please be advised that except on special occasions, First United Methodist Church does not purchase additional insurance coverage for lost, misplaced, or stolen personal items.

Check T-shirt size:

Children's __S __M __L Adult __S __M __L __XL __XXL __XXXL