

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