

HEALTH FORM FOR **2017-2018** SCHOOL YEAR
YOUTH MINISTRY

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 #: _____ Student's Cell Phone #: _____
Student's Email Address: _____

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 #: _____

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:
Adult S M L XL XXL XXXL

You may contact my Youth through: Cell Email Text Social Media