MEDICINE FORM

FOR CHURCH USE ONLY

Participant Name: _____

Participant Address: _____

Participant Age: _____ Participant Gender: ◯ Male ◯ Female

Church Name: _____

Church Address: _____

EMERGENCY CONTACT INFORMATION:

Parent/Guardian Name: _____

Parent/Guardian Cell Phone Number: (_____) _____

Parent/Guardian Work Phone Number: (_____) _____

Secondary Contact Name: _____

Secondary Contact Cell Phone Number: (_____) _____

Secondary Contact Work Phone Number: (_____) _____

MEDICAL PROFILE

In general, participant's health is: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Explain: _____

Current medical needs being treated for: _____

Please note any medical history to be aware of: _____

_____

Medication(s) that this Participant Currently Takes/Needs: _____

_____

Instructions on administering medication(s): _____

_____

Any allergies: _____

Special Diet needs to be aware of: _____

Primary Physician: _____ Phone: (_____) _____

I authorize _____ Church staff to give my child the medication(s) indicated above.

Signature of Parent/Guardian: _____ Date: _____