

**CONGREGATIONAL CHURCH OF AMHERST  
HEALTH INFORMATION SHEET**

**INSTRUCTIONS:**

THIS FORM WILL BE PROVIDED TO THE DOCTOR OR MEDICAL PERSONNEL TO WHICH YOUR CHILD IS TAKEN IN THE EVENT OF A MEDICAL EMERGENCY WHILE ON A CHURCH SPONSORED EVENT. PLEASE COMPLETE ALL SECTIONS AS ACCURATELY AS POSSIBLE.

PARTICIPANT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**EMERGENCY CONTACTS:**

MOTHER: \_\_\_\_\_ PHONE \_\_\_\_\_

FATHER: \_\_\_\_\_ PHONE \_\_\_\_\_

OTHER CONTACT: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_

**GENERAL INFORMATION:**

FOOD OR DRUG ALLERGIES: \_\_\_\_\_

OTHER ALLERGIES: \_\_\_\_\_

DATE OF LAST TETANUS SHOT: \_\_\_\_\_

PRESENT MEDICATIONS: \_\_\_\_\_

CHRONIC MEDICAL PROBLEMS: \_\_\_\_\_

OTHER ITEMS OF CONCERN: \_\_\_\_\_

\_\_\_\_\_

**PARENTAL AUTHORIZATION**

IN CASE OF MEDICAL EMERGENCY, IN THE EVENT I CAN NOT BE REACHED, I AUTHORIZE \_\_\_\_\_ TO PROCURE AND CONSENT TO ANY MEDICAL EXAMINATION, DIAGNOSTIC PROCESS OR COURSE OF TREATMENT, INCLUDING HOSPITAL CARE, TO BE RENDERED TO MY CHILD BY OR UNDER THE SUPERVISION OF ANY DULY LICENSED DOCTOR, DENTIST, SURGEON, OR OTHER HEALTH CARE PROVIDER.

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_ HEALTH INSURANCE COMPANY

\_\_\_\_\_ POLICY NUMBER