

FIRST BAPTIST CHURCH  
103 Cranberry Road  
Grove City, PA

TEEN'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
ADDRESS: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ **PARENTS** CELL PHONE: \_\_\_\_\_

**2009-10 EMERGENCY MEDICAL FORM**

In the event of illness or injury to the above-named child, I hereby authorize the youth staff member in charge, or another adult acting in that capacity, to secure the services of properly certified ambulance, rescue, EMT, physician, and/or hospital personnel.

PARENT / GUARDIAN: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_ POLICY NO. \_\_\_\_\_

In case of such an emergency, please notify the following persons in the order listed:

	<i>NAME</i>	<i>RELATIONSHIP TO CHILD</i>	<i>HOME PHONE</i>	<i>WORK PHONE</i>	<i>CELL PHONE</i>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

If unable to contact any of the above persons, I give consent to the adult in charge to make arrangements, including transportation, for medical care at Grove City Medical Center. I understand that if the situation is life-threatening, my child will be transported to the nearest available hospital.

PARENT / GUARDIAN SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

TEEN'S PHYSICIAN: \_\_\_\_\_ PHYSICIAN'S PHONE NO: \_\_\_\_\_

Briefly describe any medical conditions (illnesses, allergies, etc.) which could be of concern in the event medical treatment becomes necessary for your child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have an allergic reaction to bee stings? YES  NO  If *yes*, describe reaction: \_\_\_\_\_

Treatment to be given: \_\_\_\_\_

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

List below all medications your child is taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RETURN THIS FORM IMMEDIATELY — PLEASE NOTIFY US OF ALL UPDATES**