

Spotswood Baptist Church  
4009 Lafayette Blvd.  
Fredericksburg, VA 22408  
540-898-0757

# STUDENT

## Medical / Information Form

2015-2016

Student Name: \_\_\_\_\_ Tee Shirt Size \_\_\_\_\_ (Adult Size)

Birthdate: \_\_\_\_\_ Parent(s)/ Guardian Name: \_\_\_\_\_

Emergency Contact Numbers: Home \_\_\_\_\_ Cell #s & Name(s) \_\_\_\_\_

Cell # & Name \_\_\_\_\_ Work #s & Name(s) \_\_\_\_\_

Email Addresses (Student) \_\_\_\_\_ (Parent/s) \_\_\_\_\_

Student Mailing Address: \_\_\_\_\_

Grade \_\_\_\_\_ School Attending \_\_\_\_\_

Doctor's Name and Phone number: \_\_\_\_\_

Check box to show that a copy of insurance card (front & back) accompanies this form.

Insurance Company: \_\_\_\_\_

Policy / Group #: \_\_\_\_\_

Please list any health/medical conditions your student/child has: \_\_\_\_\_

Does he/she have any allergies? Please list... \_\_\_\_\_

Does he/she have any drug allergies? Please list... \_\_\_\_\_

Is your son/daughter currently on any medications? Please list name, dose and schedule... \_\_\_\_\_

Your child will be responsible for administering his/her own medications.

**Copy of insurance card (front & back) must accompany this form.**

\_\_\_\_ (Initial) \*I give consent for my child to receive over the counter medications.

\_\_\_\_ (Initial) \*I give my permission for the group leader or an adult chaperone to authorize medical treatment for my child at the nearest emergency care facility, should an injury or illness occur.

\_\_\_\_ Please initial if you authorize Spotswood BC to include pictures of this student on the church website and in printed material. Names WILL NOT appear in any picture descriptions.

Signature of Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**IF THERE ARE ANY CHANGES MADE DURING THE YEAR A NEW FORM WILL NEED TO BE FILLED OUT, OR YOU MAY MAKE CHANGES TO THIS FORM AND INITIAL W/ DATE.**