

Emergency Medical Information and Authorization

Praise Assembly
3535 N. Glenstone
Springfield, MO
Phone: 833-3000

Date: _____

Location: _____

Child's Name: _____ Date of Birth: _____

Address: _____ City, Zip: _____

Home Phone: (____) _____ Social Security #: _____

Father's Name: _____ Contact #: _____

Mother's Name: _____ Contact #: _____

Family Doctor: _____ Contact #: _____

Address: _____ City, Zip: _____

Insurance Company: _____ Policy #: _____

Contact #: _____

PERSONS (OTHER THAN PARENTS) TO CONTACT IN AN EMERGENCY:

Person: _____ Contact #: _____

Person: _____ Contact #: _____

Medical Questionnaire:

Please answer all the following questions. Explain any "yes" answers.

Is your Child...

...being treated for any injury or illness? YES NO

...taking any medications? YES NO

if so, please list them:

Name of Medication	Dosage	Schedule	Reason

...allergic to any for of medication? YES NO

...Have any known food allergies? YES NO

...require a special diet? YES NO

...have any chronic medical problems? YES NO

...sleepwalk? YES NO

When was their last tetanus shot? _____

If answered "yes" to any of the above questions, please explain:

Liability Release Form

We (I), on behalf of our child, assume all risk of personal injury, sickness, death, damage and expense as a result of participation in reaction and work activities involved therein.

Further, authorization and permission is hereby given to Praise Assembly to furnish any necessary transportation, food, and lodging for this participant.

The undersigned further hereby agree to hold harmless and indemnify Praise Assembly, its directors, employees, and agents, for, any liability sustained by Praise Assembly as the result of negligent, willful, or intentional acts of said participant, including expenses incurred attendant thereto.

We (I) are the parent (s) or legal guardians of this child, and grant our (my) permission for him/her to participate fully in said trip, and give our (my) permission to take said child to a doctor or hospital and hereby authorize medical treatment, including but not in limitation of emergency surgery or medical treatment, and assume the responsibility of all medical bills, if any. I understand that my personal insurance will be billed in the event of medical treatment or evaluation.

PRINTED NAME OF MINOR

PRINTED NAME OF FATHER, MOTHER OR LEGAL GUARDIAN

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE