# ATLANTA CHRISTIAN CHURCH

## Annual Medical Form

## Note: Only needed if you have not already turned in a form this year

**This permission shall be valid form the date signed, until December 31, 2024**

Attending Student or Adult's Name_____

Address _____

State _____ Zip _____ Phone _____ Birthdate _____

Emergency contact _____Phone_____

Emergency contact's relationship to attendee_____

I give my permission for the above named youth to participate in events with ***Atlanta Christian Church*** of Atlanta, IL.

I understand that, in the event medical treatment is deemed necessary by the employees or volunteers of ***Atlanta Christian Church*** for the above named attendee, an effort will be made to contact me. However, if I cannot be reached, I give my permission to the employees or volunteers of ***Atlanta Christian Church*** to secure the services of a physician to provide the care necessary, including anesthesia, for my/my child's well-being.

**In the event medical treatment is necessary, your insurance information will be necessary. Please be complete with this information.**

Insurance Company Name _____

Insurance Company Address (on back of card)_____

_____

Member ID # _____Group #_____

**Current Medication/Dosage** _____

_____

_____

_____

_____

**Allergies** _____

_____

Date of last tetanus shot (if known) _____/_____/_____

Attendee signature (if 18 or older)_____Date_____

Guardian signature (if Attendee is a minor)_____

Guardian's relationship to attendee_____