

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 from the date signed, until December 31, 2018

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 _____