

**First United Methodist Church of Evanston
2019 Master Medical Form**

Family Information

Youth Name _____ Birth Date _____ Sex _____ Age _____
Last First Middle

Parent or Guardian _____ Phone (____) _____

Home Address _____
Street & Number City State Zip

Cell Phone _____ Cell Phone _____ Email _____

Business Address _____ Business Phone (____) _____
Street & Number City State Zip

Business Address _____ Business Phone (____) _____
Street & Number City State Zip

If not available in an emergency, notify:

Name _____ Phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____

Care Providers

Name of family physician _____ Phone (____) _____

Medical/hospital insurance Carrier _____

Address: _____ Phone (____) _____

Policy # _____ Group # _____ have no medical/hospital insurance.

Please attach copy of insurance card (both sides).

Allergies

The following information must be filled in by the parent/guardian. The intent of this information is to provide our youth staff with background to provide appropriate care. Any changes to this form should be given to us as updates are necessary. List all known allergies to food, medication or other allergies.

Describe reaction and management of the reaction.

Allergies (list)

MEDICAL CONSENT FORM

Participant's Name: _____

CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE FOR MINOR.

I (Parent/Guardian full name), _____

Grant permission for my child to receive any emergency medical treatment and/or Transportation for medical/hospital treatment while participating in youth events, retreats, service projects and other activities with First United Methodist Church, 516 Church Street, Evanston, IL, 60201, and (847)864-6181.

Parent or Guardian's Signature Date