MEDICAL HEALTH RECORD

FULL NAME _____ **AGE** _____ **DATE OF BIRTH** _____ **Cell #**_____-___-_____

ADDRESS _____ **PLACE OF BIRTH** _____

PHONE NUMBER _____ **WEIGHT** _____ **HEIGHT** _____ **BLOOD TYPE** _____

IMMUNIZATION UP TO DATE: YES or NO ALLERGIC REACTIONS: _____

CONDITIONS REQUIRING MEDICATION: _____

HEALTH AND ACCIDENT INSURANCE:

COMPANY _____ **POLICY/CODE NO.** _____

REGULAR DOCTOR _____ **PHONE NUMBER** _____

OTHER INFORMATION _____

_____

PARENT OR SPOUSE INFORMATION:

FATHER/SPOUSE _____ **CELL NUMBER** _____

ADDRESS _____ **HOME PHONE** _____ **WORK PHONE** _____

MOTHER _____ **CELL NUMBER** _____

ADDRESS _____ **HOME PHONE** _____ **WORK PHONE** _____

OTHER NUMBERS/PERSONS TO CONTACT IN CASE OF EMERGENCY _____

_____

I GIVE MY PERMISSION FOR ANY FIRST BAPTIST CHURCH OF STATESBORO, GEORGIA SPONSOR TO GET MEDICAL HELP FOR MY CHILD OR MYSELF:

_____

(YOUTH / ADULT'S NAME)

I GIVE MY PERMISSION FOR _____ **TO RIDE THE FIRST BAPTIST CHURCH OF STATESBORO, GEORGIA, BUS, VAN OR OTHER VEHICLES THEY ARE USING.**

_____

(PARENT / ADULT SIGNATURE)

_____

(DATE)