

McFarland Hill Baptist Church Youth Group

MEDICAL INFORMATION

The following information will enable us to better protect your child's health & safety.

Child's Name: _____

Your Name: _____ Relation: _____

Address: _____
(include city, state and zip code)

Telephone: _____ Cell or Work Phone: _____

Persons to contact in case of an emergency

If I cannot be reached first.

Name: _____ Phone: _____

Address: _____
(include city, state and zip code)

Name: _____ Phone: _____

Address: _____
(include city, state and zip code)

Does your child have disabilities that we should be aware of? Yes: _____ No: _____

If YES, please explain:

Is your child currently taking any medications? Yes: _____ No: _____

Names(s) of Medications: _____

List of allergies: _____

Family Physician: _____ Telephone: _____

Date: _____ Parent/Guardian Signature _____