ANNUAL MEDICAL FORM

Christian Fellowship Church
January 1 – December 31, 2019

Child's Name ______________________________
Date of Birth ____________________ Age____________________
Address ____________________ City/State/Zip ____________________
Parent's Name ______________________________
Cell Phone ____________________ Parent's Work Phone ____________________
Home Phone ____________________ Emergency Phone ____________________
School ____________________ Grade ____________________

MEDICAL INFORMATION

Family Physician ______________________________
Clinic ____________________Phone ____________________
Insurance Company ____________________ Policy # ____________________
Member's Name ____________________ Insurance Company Phone ____________________
List any allergies or medical conditions that may be relevant to a physician in the event of an emergency ______________________________
Medication(s) being taken______________________________
Physical handicaps/special conditions______________________________
Designated individual to make emergency medical decisions for your child in the event you cannot be reached
Name: ______________________________
Cell Phone ____________________ Home Phone ____________________

MEDICAL CONSENT AND WAIVER including financial responsibility for property damage, transportation for discipline reasons and consent for personal property searches.

I am the parent and/or legal guardian of ______________________ and hereby acknowledge that he/she is under my care, custody, and control. In the event there arises an emergency necessitating medical/surgical attention and I am not immediately available, I expressly grant my permission and consent to the Christian Fellowship Church ("CFC"), its representatives, sponsors, or any treating physicians or personnel, to make such decisions and to perform such medical treatments and/or surgery upon my child listed above which may in their sole discretion be necessary and proper under the circumstance. I expressly waive my HIPAA rights and those of my child and authorize the medical personnel to release information they deem pertinent in their sole discretion to a CFC representative. I, the undersigned parent and/or legal guardian of the above mentioned child, do release, acquit, discharge, and covenant to indemnify, defend and hold harmless CFC, its representatives and sponsors, including their heirs, agents or assigns, from any and all actions, causes or actions, costs, damages, claims, related risk and dangers, including, but not limited to, negligence, damages, HIPAA penalties, or liabilities arising out of the treatment of any sickness or accident, and any financial responsibility for all medical treatment provided.

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I verify that my child named above is in good health and capable of participating in strenuous activities and, when necessary, will tailor their activities to those within the bounds of their physical health.

I agree to be financially responsible for all reasonable charges for health care rendered pursuant to this Consent. I also assume financial responsibility for any damage my child may cause, and for providing transportation home should it become necessary for disciplinary reasons.

I also give my permission to the CFC staff, its representatives, and the adult sponsors and chaperones to search my children's personal belongings, including but not limited to all luggage, purses, and backpacks, if deemed necessary on rare occasion for security reasons.

I agree to inform CFC immediately of any change in the information presented. All information will remain valid until revoked.

______________________________ ___________________________

Signature of Parent or Guardian *Date*

______________________________ ___________________________

Signature of Parent or Guardian *Date*

State of Indiana, County of ______________ Sworn to and subscribed before me this ______ day of ______________, 2019

______________________________ ___________________________

Notary Public for Indiana *Commission Expires*