

MEDICAL INFORMATION AND AUTHORIZATION FORM

Please PRINT your child's name in the box:

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To the staff members of VBS and Christ Lutheran Church personnel:

Should it be necessary for our child to have medical treatment while he/she is attending the Vacation Bible School activities at CHRIST LUTHERAN CHURCH on Monday, June 27 through Thursday, June 30, 2022 and we cannot be reached by phone, I hereby give the personnel permission to use their judgement in obtaining the best of such service for our child.

Signed this _____ day of _____, 2022

Signature of Parent or Guardian

Please print all information:

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|-------------------------|-------------------------|
| Parent/Guardian's Name: | Parent/Guardian's Name: |
| Address: | Home Phone: |

Phone number where the parent or guardian can be reached during the hours of Vacation Bible School (9:00 a.m.—12:00 noon).

| | |
|-------|--------|
| Name: | Phone: |
| Name: | Phone: |

Person to notify in an emergency in case you cannot be reached:

| | | |
|-------|--------|---------------|
| Name: | Phone: | Relationship: |
|-------|--------|---------------|

Your child's Physician is:

| | | |
|-------|----------|--------|
| Name: | Address: | Phone: |
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The following information is needed to protect your child from possible distress, not to exclude him/her from the program:

- Are there any foods, such as peanuts or dairy products etc., that your child is allergic to? _____
- Are there any factors which might affect the care of your child, such as asthma, allergies, diabetes, convulsive seizures, etc.? _____
- Has your child been exposed to any communicable diseases within the past 21 days? _____ If so, which one? _____
- Your child's birthday is: (Month) _____ (Day) _____ (Year) _____
- Has your child ever had a tetanus shot? Yes No If "yes," when? _____
- Is your child allergic to any medicines? Yes No If "yes," which medicines? _____
- Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity?
 Yes No
If "yes," explain: _____

If you are unsure of the answers to any of the above questions, please check with your child's physician.

**IMPORTANT: Please complete a separate medical information form for EACH child.
Doctor Visit NOT Required**

Parents or guardians will be notified immediately of any illness or accident to their child and care will be given in accordance with the parent's/guardian's wishes. Serious accident cases will be taken to the nearest clinic or hospital emergency area. Parents will be called to meet a staff member there.

Additional comments of parents or guardians: _____

If your child will be on any medication during VBS hours, please explain: _____

We are covered by the following Health Insurance:

Please complete this information for your Primary Carrier. Policy holder's name _____
Name of Employer _____ Phone _____
Address _____
Policy Number _____ Group Number _____
Carrier _____ Phone _____
Address _____

Please complete this information for your Secondary Carrier, if any. Policy holder's name _____
Name of Employer _____ Phone _____
Address _____
Policy Number _____ Group Number _____
Carrier _____ Phone _____
Address _____

If your child is NOT covered by any health insurance, please check here: