

SHALOM BAPTIST CHURCH
PERMISSION FOR EMERGENCY CARE

This form shall be readily accessible and taken to the hospital with the patient.

NAME _____
 LAST **FIRST** **MIDDLE**

DATE OF BIRTH _____

NAME OF PARENT(S) (or guardian(s) authorized to make health care decisions.)

ADDRESS _____
 STREET **CITY** **STATE** **ZIP**

HOME PHONE _____ BUSINESS PHONE (Mother) _____ (Father) _____

EMAIL ADDRESS (Mother) _____ (Father) _____

CELL PHONE (Mother) _____ (Father) _____

EMERGENCY CONTACT AFTER PARENTS _____ PHONE _____

FAMILY OR CHILD'S PHYSICIAN _____ PHONE _____

ALLERGIC TO: Medications _____

 Food _____

 Other _____

LAST TETANUS SHOT (DATE) _____

TAKING ANY MEDICATION? (TYPE) _____

OTHER MEDICAL INFORMATION _____

INSURANCE COVERAGE
 COMPANY _____

 POLICY # _____

The adult advisor(s) have my (our) permission, in any emergency to take my (our) child, at my (our) expense, to the hospital emergency room deemed appropriate by the rescue squad or the adult advisor(s). The hospital and its medical staff have my (our) authorization to provide treatment which a physician deems necessary for the well-being for my (our) child.

Commonwealth of Virginia

Signature of Parent/Guardian

County/City of _____

This _____ day of _____,

known or adequately identified to me, personally appeared before me and subscribed his/her signature hereto.

Date _____

Notary Public

My Commission Expires: _____