NEW LIFE CHRISTIAN FELLOWSHIP

580 N State Road
Medina, OH 44256
(330) 723-4443

MEDICAL EMERGENCY CARE INFORMATION FORM

As parent or guardian of the named child, I hereby give my consent to administer necessary medical treatment by a qualified and licensed medical doctor in the event of a medical emergency, which in the opinion of the attending physician, may endanger the life of my child, cause disfigurement, physical impairment or undue discomfort, if delayed. I give my consent to transport by ambulance if the situation warrants such action. My signature also serves to indicate my willingness to take full financial responsibility for any and all medical services rendered and thus releases New Life Christian Fellowship Church from this liability.

Note that this consent will be exercised only after a reasonable effort has been made to contact the parent or guardian and emergency contact person.

_____

Child's Name

_____

Address (if different from reverse "Registration Information")

_____ _____

Signature of Parent / Guardian **Date**

_____ _____

Signature of Emergency Contact (if different from Parent/ Guardian) **Emergency Phone Number**

_____ _____

Print Name of Emergency Contact **Home Phone Number**

MEDICAL INFORMATION

Name of Physician: _____ **Physician Phone Number:** _____

Insured Designated Hospital: _____

Insurance Company Covering Child: _____

Policy Number: _____ **Expiration Date:** _____

Allergies of Child/Chronic Illnesses/Other Conditions: _____

_____

_____

Date of Last DPT or Tetanus: _____