

**Faith Bible Fellowship Church  
Harleysville, PA**

**Health Form valid August 2017 through July 2018**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Birth date: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Medical Insurance Co.: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group: \_\_\_\_\_

List any Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

List any Allergies (especially to medications): \_\_\_\_\_

\_\_\_\_\_

List any Current Medications (include prescriptions & over-the-counter items):

\_\_\_\_\_

Does your child wear contact lenses? Yes / No

Name of Parent or Guardian: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

\_\_\_\_\_

Home Phone (     ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (     ) \_\_\_\_\_ - \_\_\_\_\_

Dad's Cell (     ) \_\_\_\_\_ - \_\_\_\_\_ Mom's Cell (     ) \_\_\_\_\_ - \_\_\_\_\_

Name of alternate person to contact (should live near person named above):

\_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (     ) \_\_\_\_\_ - \_\_\_\_\_

I, who by law may do so, authorize the admission of emergency medical treatment to the subject of this form. I understand all reasonable safety precautions will be taken at all times by Faith Bible Fellowship Church of Harleysville and its agents liable for any accident, injury or disease incurred by the subject of this form. I understand that in the event that medical intervention is needed, every attempt will be made to contact the person(s) above immediately.

Signature of Parent/Guardian

\_\_\_\_\_ Date: \_\_\_\_\_