**Faith Bible Fellowship Church**
**Harleysville, PA**

**Health Form valid August 2018 through July 2019**

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: _____