New Song Church
Students In Ministry
Medical Waiver

Student's name_____Age____DOB_____

Address _____City_____ Zip_____

Home Phone #_____ School_____ Grade_____

Parent/Guardian business phone # _____ cell # _____
business phone # _____ cell # _____

To Whom It May Concern:
The undersigned does hereby give permission for my/our child_____, to attend and participate in activities sponsored by New Song Church from May 1, 2003 to January 31, 2004.

I/We authorize any adult leader of the New Song SIMS activity, in their sole discretion, to consent to any necessary medical treatment, including but not limited to, any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, as well as hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for my/our child to return home due to a medical reason or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for my/our child to ride in any vehicle designated by the adult leaders of New Song SIMS while attending and participating in activities sponsored by New Song Church.

Hospital Insurance: Yes___ No___ Insurance Co._____
Policy # _____Group #_____

_____
(signature of parent or guardian)

Emergency Contact:

_____ _____
Name Phone #

_____ _____
Name Phone #

Health History:

Pre-existing or present medical conditions:_____
Please include any major illnesses or injuries which occurred during the past year.

Child's doctor:_____phone_____

orthodontist_____phone_____

My child is now taking the following medications:

Medication:_____Dosage_____

Date of last tetanus shot:_____Contact Lenses:_____

Activity and/or Swimming Restrictions:_____

My child has the following allergies: _____

_____

Effective treatment for allergy symptoms: _____

My child may take the following over-the-counter medications: (ex. Tylenol, Advil, Benadryl)_____

My child is a practicing vegetarian _____yes _____no

Special dietary needs: _____

_____

Special information about my child that you really need to know:_____

_____