

MEDICAL FORM
Eau Gallie First Baptist Church
1501 W. Eau Gallie Blvd.
Melbourne, Florida 32935
Phone: 321-254-2339
For all Student Ministry Activities 2010

NAME _____ AGE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

IN CASE OF EMERGENCY NOTIFY _____

RELATIONSHIP _____ PHONE _____

FAMILY PHYSICIAN _____ PHONE _____

FAMILY MEDICAL INSURANCE CO. _____

POLICY NUMBER OR IDENTIFICATION NO. _____

MEDICAL HISTORY
(please use back of sheet if necessary)

Asthma ___ Sinusitis ___ Bronchitis ___ Kidney trouble ___ Heart ___ Diabetes ___

Other: _____

Allergies: Food _____

Drugs _____

Bites/Stings _____

Previous Operations/Serious
Illnesses: _____

Current Medications (by name, Rx #, prescribing
physician): _____

(For Adults Over the Age of 18): In the event that I become ill or injured, I consent, to any medical or surgical diagnosis and/or treatment and hospital care, and the administration of drugs or medicine that is deemed necessary by the attending physician. I also agree to bear any expenses arising from said emergency treatment.

Signature: _____

(For Minors Under the Age of 18): In the event that my child becomes ill or injured, I give full consent to any medical or surgical diagnosis and/or treatment and hospital care, and the administration of drugs or medicine that is deemed necessary by the attending physician. I also agree to bear any expenses arising from said emergency treatment.

Signature of Parent or Legal Guardian: _____

NOTARY SECTION

State of Florida – County of Brevard

The foregoing instrument was acknowledged before me this _____ day of _____, 2010 by _____, who is known to me or produced _____ as identification and who did take an oath.

(type or write name of notary)