

First Baptist Church Surfside Beach
711 16th Avenue North
Surfside Beach, SC 29575
(843) 238-0206

Authorization for Medical Treatment (Child)

DATE: _____

TO WHOM IT MAY CONCERN:

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child _____, SS# (Optional) _____, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if the situation warrants.

I understand that my child will be responsible for administering ANY PRESCRIPTION MEDICATION while on any trip. I will be financially responsible for any medical care. I understand that this medical authorization is effective from JANUARY 1, 2012 to JANUARY 31, 2013.

I understand that I am responsible for notifying First Baptist Church Surfside Beach of any changes in the medical conditions and/or information concerning my child during the above effective dates.

NAME OF CHILD: _____ D.O.B. _____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

NAME OF FAMILY PHYSICIAN: _____ PHONE: _____

ALLERGIES OF CHILD: _____

LAST MEDICAL ATTENTION: TYPE: _____ DATE: _____ PHYSICIAN: _____

DATE OF LAST DPT OR TETANUS: _____

NAME OF INSURANCE COMPANY (MEDICAL): _____

POLICY #: _____ EXPIRATION DATE: _____

EMERGENCY PHONE NUMBERS:

FATHER'S NAME: _____ WORK#: _____ HOME#: _____

PLACE OF EMPLOYMENT: _____ SS#: (Optional) _____

MOTHER'S NAME: _____ WORK#: _____ HOME#: _____

PLACE OF EMPLOYMENT: _____ SS#: (Optional) _____

RELATIVE: _____ RELATIONSHIP: _____ PHONE #: _____

FAMILY MEDICAL HISTORY: Has any blood relative ever had any of the medical conditions listed below? Please check the correct response. (Please leave nothing blank)

Medical Condition	Yes	No	Medical Condition	Yes	No	Medical Condition	Yes	No
Cancer			Diabetes			High Blood Pressure		
Tuberculosis			Kidney Disease			Stroke		
Epilepsy			Heart Trouble			Bleeding Disease		
Other:			Other:			Other:		

Please complete back also.

SERIOUS INJURIES: (Such as concussion, fracture, etc.) Please list below. If none, please write "NONE" across the table below.

Type of Injury	Date	Physician	Physician Phone #

PERSONAL MEDICAL HISTORY: Have you ever had any of the medical conditions listed below? Please check the correct response.

Medical Condition	Yes	No	Medical Condition	Yes	No	Medical Condition	Yes	No
In the past ten years have you had a PPD (TB Skin Test)			In the past ten years have you had a Tetanus Shot			Other: _____ _____		
Red Measles			German Measles			Mumps		
Whooping Cough			Diphtheria			Small Pox		
Chicken Pox			Typhoid Fever			Influenza		
Pneumonia			Scarlet Fever			Tuberculosis		
Polio			Meningitis			Asthma		

ALLERGIES: If you have any of the allergies below, please check the correct response. (Please leave nothing blank)

Allergy	Yes	No	Reaction (If Yes)	Allergy	Yes	No	Reaction (If Yes)
Penicillin				Eggs			
Sulfa				Insect Bites			
Bartitirates				Other Allergy			

PREVIOUS SURGERIES: Please list below. If none, please write "None" across the table.

Previous Surgeries	Date	Physician	Physician Phone #

PREVIOUS HOSPITALIZATIONS: Please list below. If none, please write "None" across the table.

Previous Hospitalizations	Date	Physician	Physician Phone #

Signature of Parent or Guardian: _____

NOTARIZATION REQUIRED:

Witness my hand and official seal, this _____ day of _____ A.D. _____

My commission expires: _____

Notary Public _____ State of South Carolina at large, County of _____