ANNUAL MEDICAL FORM

Christian Fellowship Church
January 1 – December 31, 2024

Child's Name _____
Date of Birth _____ Age_____
Address _____ City/State/Zip_____
Parent's Name _____
Cell Phone _____ Parent's Work Phone _____
Home Phone _____ Emergency Phone _____
School _____ Grade _____

MEDICAL INFORMATION

Family Physician _____
Clinic _____Phone _____
Insurance Company _____ Policy # _____
Member's Name _____ Insurance Company Phone _____
List any allergies or medical conditions that may be relevant to a physician in the event of an emergency _____
Medication(s) being taken _____
Physical handicaps/special conditions _____
Designated individual to make emergency medical decisions for your child in the event you cannot be reached
Name: _____
Cell Phone _____ Home Phone _____

MEDICAL CONSENT AND WAIVER including financial responsibility for property damage, transportation for discipline reasons and consent for personal property searches.

I am the parent and/or legal guardian of _____ and hereby acknowledge that he/she is under my care, custody, and control. In the event there arises an emergency necessitating medical/surgical attention and I am not immediately available, I expressly grant my permission and consent to the Christian Fellowship Church ("CFC"), its representatives, sponsors, or any treating physicians or personnel, to make such decisions and to perform such medical treatments and/or surgery upon my child listed above which may in their sole discretion be necessary and proper under the circumstance. I expressly waive my HIPAA rights and those of my child and authorize the medical personnel to release information they deem pertinent in their sole discretion to a CFC representative. I, the undersigned parent and/or legal guardian of the above mentioned child, do release, acquit, discharge, and covenant to indemnify, defend and hold harmless CFC, its representatives and sponsors, including their heirs, agents or assigns, from any and all actions, causes or actions, costs, damages, claims, related risk and dangers, including, but not limited to, negligence, damages, HIPAA penalties, or liabilities arising out of the treatment of any sickness or accident, and any financial responsibility for all medical treatment provided.

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I verify that my child named above is in good health and capable of participating in strenuous activities and, when necessary, will tailor their activities to those within the bounds of their physical health.

I agree to be financially responsible for all reasonable charges for health care rendered pursuant to this Consent. I also assume financial responsibility for any damage my child may cause, and for providing transportation home should it become necessary for disciplinary reasons.

I also give my permission to the CFC staff, its representatives, and the adult sponsors and chaperones to search my children's personal belongings, including but not limited to all luggage, purses, and backpacks, if deemed necessary on rare occasion for security reasons.

I agree to inform CFC immediately of any change in the information presented. All information will remain valid until revoked.

_____ _____

Signature of Parent or Guardian *Date*

_____ _____

Signature of Parent or Guardian *Date*

State of Indiana, County of _____ Sworn to and subscribed before me this _____ day of _____, 2024.

_____ _____

Notary Public for Indiana Commission Expires