

## Church Medical & Medication Authorization Form

Participant Information Full Name: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Address: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  Male  Female \_\_\_\_\_

Church Information Church Name: \_\_\_\_\_

Church Address: \_\_\_\_\_

Emergency Contact Information Parent/Guardian

Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Secondary Contact Name: \_\_\_\_\_

Secondary Contact Phone: \_\_\_\_\_

Medical Profile Overall Health:  Excellent  Good  Fair  Poor

Explanation (if not Excellent): \_\_\_\_\_

Medical Needs Currently Being Treated:

\_\_\_\_\_

Medical History We Should Be Aware Of:

\_\_\_\_\_

Allergies & Special Needs Allergies: \_\_\_\_\_

Special Diet Needs: \_\_\_\_\_

Current Prescription Medication(s)

\_\_\_\_\_

Instructions for Administration:

\_\_\_\_\_

Physician Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Over-the-Counter (OTC) Medication Authorization Check all that apply.**

- Acetaminophen (e.g., Tylenol)
- Ibuprofen (e.g., Advil, Motrin)
- Antihistamines (e.g., Benadryl)
- Cough Drops
- Antacid (e.g., Tums)
- Topical Ointments (e.g., Neosporin, hydrocortisone)
- Eye Drops  Other (please specify): \_\_\_\_\_

Dosage Instructions (if different from package):

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**I have attached a copy of my child's health insurance.**

Please circle one that you have included your insurance card.

Yes or No

Consent & Authorization I, the undersigned parent/legal guardian, authorize the designated staff of Venture Church to administer both prescribed and over-the-counter medications to my child as noted above. I understand that OTC medications will be administered as needed, and efforts will be made to contact me unless in an urgent situation.

Signature of Parent/Guardian: \_\_\_\_\_ Date  
(MM/DD/YYYY): \_\_\_\_\_