MEDICAL INFORMATION

Please fill out, sign & date this form so we can meet any special needs your child has & so we have enough information in case of an emergency.

PERSONAL INFORMATION

Name of Child ____________________________ Birthday ___/___/___ Sex **M / F** *Age ____

Hair color ______ Height _____ Weight _____ Eye Color _____ Grade this Fall ______

Wears glasses? **Yes/No** Wears contact lenses? **Yes/No**

*Parent or guardian ___________________________ *Home Phone #______________

*Address ____ *Work Phone #______________

*City __________________ State _____ Zip Code _______ *Emergency Phone #__________

*Health Insurance Company _______________________________ Policy # __________________

***Insured Parent's Work Phone #__________________**

(CEF's insurance pays only for accident expense not covered by your family insurance & does not cover illness, such as colds, flu, appendicitis, etc.)

Family doctor ___________________________________ Address __________________________

City/State/Zip ____ Phone _______________

MEDICAL HISTORY

Allergies to medications ____

Other allergies ____

Approximate date of last Tetanus Shot ____/____/____

Any known tendency to (check all that apply):

- ❑Earaches
- ❑Asthma
- ❑Hyperactivity
- ❑Hay fever
- ❑Insomnia
- ❑Headaches
- ❑Sleep-walking
- ❑Homesickness
- ❑Nervousness
- ❑Epileptic convulsions
- ❑Bedwetting
- ❑Stomach Aches
- ❑Other ____________________________

Any illnesses or accidents; date & status: ____

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Does your child need any medications? **Yes/No** Name of medication(s) _________________

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How often/What time of the day? _______________

In addition to prescribed medications, my child has my permission to receive the following over-the-counter drugs: (circle the drugs you approve) **Tylenol, Advil, Cough Syrup, Stomach antacid, Decongestant, Antihistamine, Other** ______________________________________

List heath or other conditions that would limit child's participation in CEF® activities:

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MEDICAL CONSENT/LIABILITY RELEASE STATEMENT

I hereby release Child Evangelism Fellowship® Inc., its staff, board members, & agents from responsibility & liability for any injury or illness that my child may sustain during the above-mentioned CEF® program. I hereby give permission for my child to receive medical treatment in the event of an emergency. I expect to be contacted as soon as possible.

____ ____________________

Signature of Parent or Guardian Date