Long Island Abundant Life Church

Children's Ministry

MEDICAL INFORMATION & AUTHORIZATION FORM- Children's Ministry Programs

NOTE: Parent/Guardian is responsible for updating the school when any information in this form changes.

Student Information

Student name ____ Grade to enter ____________
First Middle Last

Name(s) of parent or legal guardian____

Street address __________________________________ Parent email _____________________________

City _______________________________________State _____________ Zip Code___________________

Parent's phone (home) __________________________________ (cell) ____________________________

Student's birthdate (M/D/Y) _____/_____/_____ Sex M F Age as of (*First day of school*) _________

Known allergies ____

Other known medical conditions or concerns ____
(More complete information will be filled out below)

Permission to contact non-custodial parent? Yes/No N/A If yes, provide name and phone number for non-custodial parent:

____ /__________________________
Name Phone

Name of medical insurance company ____________________________ Policy #___________________

Name of insured ____

Employer of insured____

Primary health care provider ______________________________________ Phone ___________________

Dental provider____ Phone_________________________

The following information will be used to contact those persons who will be responsible for making emergency medical decisions on behalf of the child listed above. Parental or guardian contact information must be updated if/when it changes. ONLY LIST THE NAMES OF THOSE WHO HAVE AUTHORITY TO MAKE DECISIONS IN AN EMERGENCY SITUATION INVOLVING THIS CHILD. List at least one person who may be contacted in an emergency in the event the parents or guardians are unavailable. Additional persons and their contact information can be listed on the back of this form.

Mother's name _____________________________________Cell______________Home_______________
Last First

Address ____
Street City State Zip

Mother's Employer ____
Name Address Work Phone

Father's name _____________________________________Cell______________Home_______________
Last First

Address ____
Street City State Zip

Father's Employer ____
Name Address Work Phone

ADDITIONAL EMERGENCY CONTACT

Name ____________________________________ Cell ___________________Home____________________
Last First

Address ____
Street/Apt.# City State Zip

Employer ____
Name Address Work Phone

MEDICAL CONDITIONS

Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

Child's Name ____Birth Date _____________

Medical Condition(s): ____

____

Medications currently being taken by your child: ____

____

Allergies/Reactions: ____

____

EMERGENCY MEDICAL INSTRUCTIONS

(1) Signs/symptoms to look for: ____

____

(2) If sign/symptoms appear, do this: ____

____

(3) To prevent incidents: ____

____

In EMERGENCIES requiring immediate medical attention, your child will be taken to the nearest hospital emergency room. Your signature below authorizes the responsible person at LIALC to have your child transported to that hospital. It also authorizes LIALC personnel to contact the child's primary care or dental provider, in the event of an emergency.

I HEREBY GIVE PERMISSION FOR THE THOSE RESPONSIBLE FOR MY CHILD AT LIALC TO AUTHORIZE MEDICAL TREATMENT FOR MY CHILD IN THE EVENT OF AN EMERGENCY.

Signature of Parent/Guardian __________________________________Date_________

Signature of Parent/Guardian __________________________________Date_________