West Hartsville Baptist Church

1003 WEST CAROLINA AVENUE
HARTSVILLE, SOUTH CAROLINA
(843) 332-6221
Fax: (843) 332-0580
www.westhartsville.org

Medical Profile & Release

Name of child: _____ Date of birth: _____
Address: _____
Phone number: _____ Sex: _____ Height: _____ Weight: _____

Insurance and doctor information:
Do you have health insurance? _____
Name of insurance company: _____
Policy number: _____ Group number: _____
Name listed on policy: _____ Insurance phone number: _____
Doctor's name: _____ Phone number: _____
City/State: _____
Dentist's name: _____ Phone number: _____
City/State: _____

Health information:
Please list current medications taken by minor and dosage: _____
_____
Please list any known pre-existing conditions: _____
_____
Please list all known allergies: _____
Date of last tetanus shot: _____
Does the child wear contact lenses? _____ Glasses? _____
List any known restrictions or other special physical or dietary needs: _____
_____
_____

Contact information:
Parent/Guardian contact: _____ Address: _____
Phone numbers: _____(home) _____(work) _____(mobile)
In case of emergency notify: _____ Address: _____
Phone numbers: _____(home) _____(work) _____(mobile)

Being the parent or legal guardian of _____, I _____ do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader of *West Hartsville Baptist Church* to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care. Further, as parent or legal guardian I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child. Any policy of the church or organization sponsoring this event will be used as the secondary coverage.

Parent/Guardian signature: _____ Date completed: _____

Notary Acknowledgement
State of South Carolina
County of Darlington

Personally appeared before me, _____, who acknowledged that he/she executed the within instrument for the purposes therein contained.

Witness my hand this _____ day of _____, 20_____

Notary signature: _____ My commission expires: _____

"We're Here Because of Christ"