



FIRST BAPTIST CHURCH
AUTHENTIC YOUTH MINISTRY
CONSENTIMIENTO MEDICO
 Phone # (903) 675-5135 Fax # (903) 675-4708

NOMBRE (completo) DEL ESTUDIANTE: _____

TELEFONO DEL ESTUDIANTE: _____

DIRECCION: _____

NOMBRE DEL PADRE/MADRE: _____

CORREO ELECTRONICO: _____

TELEFONO: _____ MOBIL: _____

GRADO: _____ ESCUELA: _____ EDAD: _____ FECHA DE NACIMIENTO: _____

LA LEY REQUIRE LA SIGUIENTE INFORMACION DE CADA PERSONA.

SEGURO MEDICO: _____ I.D. #: _____ (NECESITO UNA COPIA) DIRECCION: _____ CODIGO POSTAL: _____ NO. TELEFONO: _____ Por este medio autorizo que (nombre del estudiante), _____ reciba cuidado medico y, de ser necesatio, hospitalizacion. El estudiante sera llevado al hospital y sera atendido por los doctores. FIRMA: _____ NO. TELEFONO: _____

SI EL PADRE O LA MADRE NO ESTAN DISPONIBLES, ¿CON QUIEN PODEMOS COMUNICARNOS?:

1. _____ TELEFONO: _____

2. _____ TELEFONO: _____

MEDICO DE LA FAMILIA: _____ TELEFONO: _____

¿ALERGIAS?: _____

¿ALERGIAS A ALGUN MEDICAMENTO? _____ CUALES: _____

¿ESTA TOMANOD ALGUN MEDICAMENTO?: _____

¿ALGUNA VEZ HA SIDO DIAGNOSTICADO CON ALGUNAS DE LAS SIGUIENTE CONDICIONES?:

___ DIABETES ___ EPILEPSIA ___ ASMA ___ PROBLEMAS CARDIACOS ___ PROBLEMAS DE TIROIDE ___ FIEBRE REUMATICA

SI LA RESPUESTA HA SIDO “SI” A ALGUNA CONDICION, DE MAS DETALLES: _____



FIRST BAPTIST CHURCH
AUTHENTIC YOUTH MINISTRY
MEDICAL RELEASE FORM
Phone # (903) 675-5135 Fax # (903) 675-4708

STUDENTS (full) NAME: _____

STUDENTS PHONE #: _____

ADDRESS: _____

PARENT OR GUARDIAN: _____

ADDRESS (IF DIFFERENT FROM ABOVE): _____

E-MAIL ADDRESS: _____

HOME/CELL PHONE: _____ WORK PHONE: _____

GRADE LEVEL: _____ SCHOOL: _____ AGE: _____ DATE OF BIRTH: _____

STATE LAW REQUIRES THE BELOW INFORMATION ON EVERYONE.

INSURANCE COMPANY: _____ I.D. #: _____
(NEED COPY)

ADDRESS: _____

ZIP CODE: _____ PHONE: _____

I hereby authorize (student's name) _____ to obtain medical care and services as well as hospitalization, if necessary, and that he/she will be taken to a local hospital and will be attended by a physician on call there.

SIGNATURE: _____ PHONE: _____

CONTACT PERSONS IF PARENT/GUARDIAN IS NOT AVAILABLE:

1. _____ PHONE: _____

2. _____ PHONE: _____

FAMILY PHYSICIAN: _____ PHONE: _____

ALLERGIES: _____

ARE YOU ALLERGIC TO ANY MEDICATION? _____ SO, PLEASE LIST BELOW: _____

MEDICATION YOU ARE CURRENTLY TAKING: _____

HAVE YOU EVER BEEN TOLD YOU HAD ANY OF THE FOLLOWING?:

___ DIABETES ___ EPILEPSY ___ ASTHMA ___ HEART TROUBLE ___ THYROID TROUBLE ___ RHEUMATIC FEVER

IF THE ANSWER TO ANY OF THESE CONDITIONS IS YES, PLEASE EXPLAIN: _____

NOTES: PARENTS WILL BE CONTACTED IF THERE ARE MEDICAL PROBLEMS.

This form can be faxed to the Student Ministry at (903) 675-4708 or e-mailed to Jorge@authenticyouth.com