Franklin Christian Church

Medical Information

Please Print

Name____ Date of Birth__________________

Address____________________ City____________________State________ Zip____________

Social Security number____

Insurance company________________________________ policy #__________________

Primary care physician (name)__________________________ phone__________________

In case of emergency notify:

Primary contact (name)______________________________ phone__________________

Secondary contact (name)____________________________ phone__________________

Immunizations:

___ Tetanus ____ Polio Booster ____ Measles ____ Mumps ____ Other Hepatitis A

Current or former conditions:

____ Asthma ____ Sinusitis ____ Bronchitis ____ Kidney disease/condition

____ Dizziness ____ Hay fever ____ Intestinal disorder ____ Diabetes

____ Heart disease/condition (including murmur, mitral valve prolapse, etc.)

____ Other (please specify)____

Please provide specifics of any condition indicated:______________________________

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Allergy information:

Food (list type)____

Penicillin or other drug (name)____

Insect stings/bites____

Poison sumac, oak, or ivy____

Previous operations or serious illnesses____________________________________

Current medications (list)____

Special diet/dietary restrictions (name)____________________________________

Childhood Diseases:

____ Chicken pox ____ Measles ____ Mumps ____ Whooping Cough

____ Other____

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Permission for treatment:

My permission is granted for representatives of Franklin Christian Church to obtain necessary medical attention in case of sickness or injury to myself and/or in the event that I am unable to give said permission.

Signature____ Date__________________

Signature of parent or guardian*___________________________ Date__________________

**Required if volunteer is a minor*

3/2001