

REGISTRATION AND MEDICAL CONSENT FORM

Name: _____ Phone: _____

Address: _____ City and State: _____ Zip: _____

Dates of Activity: _____ Birthdate: _____ Gender: _____

EMERGENCY CONTACT

ALT. CONTACT

Name: _____ Name: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

ALLERGIES

- Drugs
- Asthma
- Hay Fever
- Insect Stings
- Food Allergies

HEALTH HISTORY

- Diabetes
- Cardiac
- Chronic Asthma
- Nervous Disorder
- Epilepsy
- Physical Handicap

- Emotional Handicap
- Mental Handicap
- Seizure Disorder
- Other
- Date of last
Tetanus Shot

If you have checked any of the above, please give details: _____

Activity Restriction: _____

This health history is correct, so far as I know. I hereby give my permission to the physician, nurse, or dentist selected by _____ to secure medical and dental aid as required for illness or injury under a physician's orders including transportation to and from the necessary facilities.

Signature _____ Date

(Parent or Guardian if youth is minor or dependant)

PARENT/GUARDIAN CONSENT FORM

I _____ am the parent or legal guardian of _____
(hereinafter "my child"), and I am informed of the activity _____

_____ offered by New Life Christian Fellowship's Youth Group, located at 1574 W. State Road 234, Fortville, IN 46040, beginning: _____ and ending on the day of _____.

As Parent or legal Guardian of my child, I hereby give consent for my child to attend and participate in all activities provided by New Life Christian Fellowship.

Signature _____ Date

(Parent or Guardian if youth is minor or dependant)