

Hesperia Community Church  
Medical Consent & Media Authorization Form  
(760) 244-2805

**Please Print**

Name \_\_\_\_\_ Sex: M F Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
Last First circle one

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Grade \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Grade in the Fall of 20\_\_

**EMERGENCY INFORMATION:**

Father's Name or Legal Guardian \_\_\_\_\_

Mother's Name or Legal Guardian: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Pager (\_\_\_\_) \_\_\_\_\_

Pager (\_\_\_\_) \_\_\_\_\_

**If Parents or Guardian are unavailable, call:**

Alternate Contact/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health & Insurance Information**

Do you carry family medical/hospital insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, indicate Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Family Dentist/Orthodontist \_\_\_\_\_ Phone # \_\_\_\_\_

**MAJOR MEDICAL PROBLEMS**

Allergies: Asthma \_\_\_\_\_ Drug Allergies \_\_\_\_\_ Hay Fever \_\_\_\_\_ Insect Stings \_\_\_\_\_ Other Allergy \_\_\_\_\_

Asthma(chronic) \_\_\_\_\_ Bleeding/Clotting Disorder \_\_\_\_\_ Cardiac \_\_\_\_\_ Diabetes \_\_\_\_\_ Epilepsy \_\_\_\_\_ Emotional Disorder \_\_\_\_\_

Nervous Disorder \_\_\_\_\_ Physical Handicap \_\_\_\_\_ Seizure Disorder \_\_\_\_\_ Other condition \_\_\_\_\_

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

Activity Restrictions? \_\_\_\_\_

List operations or serious injuries with dates: \_\_\_\_\_

List any chronic, recurring illness or medical condition: \_\_\_\_\_

Current medication: (send with instructions) \_\_\_\_\_

Date of last tetanus shot: (mo/day/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_

**IMPORTANT: Please notify Hesperia Community Church (HCC) if your child has been exposed to a communicable disease within three weeks prior to an outing or event.**

This health information is correct so far as I know, and the person described has my permission to engage in all prescribed activities except as noted. **Authorization for treatment:** I hereby give permission to the medical personnel selected by HCC to order X-rays, routine tests, treatments; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by HCC to secure and administer treatment, including hospitalization, for the person named above. This form, when complete, may be photocopied for trips away from the Church.

**Media Authorization:** I hereby also give HCC permission to use any audio, video and/or photography of my child for HCC's promotional purposes including but not limited to internet, printed media and videos.

Signature of Parent of Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_