EASTVIEW MEDICAL CONSENT FORM

Name _____Birth date_____ Sex _____

Address _____ Phone _____ Cell Phone: _____

City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION:

Contact _____ Phone _____ Cell Phone: _____

Address _____ City _____ State _____

If attempts to reach the above contacts are unsuccessful, please contact my physician:

Doctor _____ Phone _____

Address _____

HEALTH HISTORY (CIRCLE ALL THAT APPLY)

Allergies	Asthma	Insect Sting Reaction
Drug Allergies	Hay Fever	Diabetes
Nervous Disorder	Emotional Handicap	Physical Handicap
Epilepsy	Seizure Disorder	Mental Handicap
Cardiac Problems	Chronic Asthma	Other _____

If you circled any of the above, please give specific details (use back if necessary):_____

_____

_____

Activity restrictions: _____

_____

Date of last Tetanus Shot: _____

Please list any other medical issues (physical or mental) that your team leader, Eastview's Global Outreach Dept., or our Global Partner needs to know about. Anything withheld could prevent us from properly assisting you in an emergency. _____

INSURANCE INFORMATION:

Policyholder _____ Name of insurance company _____

Policy Number _____

This health history is correct, to the best of my knowledge. In the event that the named individuals cannot be reached, I hereby give my permission to the physician or dentist selected by Eastview Christian Church, to hospitalize, to secure proper treatment, and/or to order an injection, anesthesia, or surgery as deemed necessary.

I also authorize Eastview Christian Church sponsor(s) to administer medical aid as required for illness or injury under a physician's orders.

Signature: _____ Date: _____

Notary: _____ Date: _____