

**MEDICAL CONSENT FORM FOR 2007 CALENDAR YEAR**  
**La Verne Heights Presbyterian Church, 1040 Baseline Road, La Verne, CA 91750**

Required by State Law for students under 18 Years of age.

Name of Student: \_\_\_\_\_  
Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_  
Address \_\_\_\_\_ Apt# \_\_\_\_\_ Grade \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Social Security # \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of Parents \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**Alternate Contact:**

1. Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_

Relationship \_\_\_\_\_

2. Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_

Relationship \_\_\_\_\_

**Health & Insurance Information**

Do, you have family health insurance? ? Yes? No  
If yes, indicate which Insurance Carrier: \_\_\_\_\_ Policy# \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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

List any Allergies: \_\_\_\_\_

Major Problems: ? Asthma (chronic) ? Bleeding/Clotting Disorders ? Cardiac ? Diabetes ? Epilepsy ? Nervous Disorder  
? Emotional Handicap ? Seizure Disorder ? Physical Handicap ? Other \_\_\_\_\_

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

Any Activity restrictions: \_\_\_\_\_

List any operations or serious injures (include dates): \_\_\_\_\_

List any current medications: \_\_\_\_\_

Anything else we should know regarding your child's health: \_\_\_\_\_

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

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