

**FIRST BAPTIST CHURCH**  
620 Fourth Street  
Graham, TX 76450

**CHILDRENS MINISTRY**

940-549-2360

**FOR JANUARY 1, 2008 –DECEMBER 31, 2008**

**HEALTH AND REGISTRATION INFORMATION**

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Current Grade (completed): \_\_\_\_\_ Child's Weight: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Are you and your family members of First Baptist Church? \_\_\_\_\_ If no, are you active in a local church? \_\_\_\_\_

If yes, where? \_\_\_\_\_

**MEDICAL INFORMATION**

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Physical disorders: (diabetes, epilepsy, asthma, fainting, heart condition, or other) \_\_\_\_\_

Has your child been diagnosed hyperactive, ADD, or Learning Disabled? \_\_\_\_\_

If yes, please give diagnosis and describe treatment and special instructions:

\_\_\_\_\_

List all medications currently taking: \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Can child take part in regular activities including swimming? \_\_\_\_\_ Swim in shallow end only? \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

**Mother's Name:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Other Emergency Contact:**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**MEDICAL TREATMENT AUTHORIZATION**

\_\_\_\_\_ has my permission to engage in prescribed activities, except as noted by me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by an adult leader in charge, to order injections, surgery, or any other medical and/or dental treatment that me be deemed necessary to insure the well-being of the above named. I also authorize the adult leader (s) in charge to transport my child at their discretion in case of an emergency.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Printed Name: \_\_\_\_\_

**Please attach a copy of your family insurance card**

**NON-PRESCRIPTION MEDICATIONS**

The following non-prescription medications will be available at our first aid station for your child if necessary. Your permission is necessary before any medication can be administered. Any medication you **DO NOT** wish your child to have **SHOULD BE CIRCLED**: **Robitussin** (for cough, congestion, etc.) **Tylenol** (for headache, fever, general aches) **Mylanta** (for upset stomach) **Benadril** (for itching or antihistamine for relief of allergy symptoms)

List any other Medications, (Prescription and Non-Prescription) that you give your permission for your child to take:

\_\_\_\_\_

Child's Name: \_\_\_\_\_ has my permission to take the above if deemed necessary by the adult leader in charge of first aid.

Parent's Signature: \_\_\_\_\_

Date form completed: \_\_\_\_\_