GRACE MEDICAL INFORMATION/CONSENT TO TREATMENT FORM
Grace Christian Fellowship, PCA, Inc. ("Grace")
495 Cardinal Rd, Mills River, NC 28759 – 828.891.2006

Participant's Full Name: Birth Date: Grade:

Address: City, State, ZIP:

Home/Cell Phone: Emergency Contact Name and Phone:

Email: Social Security Number (used only if required for medical attention):

Known Allergies (specific medicine, food, etc.) -

Any special dietary or physical constraints or needs –

List any medication being taken -

Date of last tetanus shot –

Family physician -
Address: City, State, ZIP:

Name of health insurance carrier - Phone number of insurance carrier –

Policy number -

Other policy identification number of the policy member (i.e. parent) -

CONSENT TO MEDICAL TREATMENT FOR MINORS

I hereby give consent to emergency medical treatment for my child to be secured by the activity or event sponsor or designated staff members of Grace. I understand that I will be notified as promptly as possible in the event of an emergency.

Signature of adult participant or parent/guardian: _____
Date:_____

[_] Check here if you do not want the Participant's picture published online or otherwise in connection with publicity for this event or Grace.

ACKNOWLEDGEMENT BY LEGALLY RESPONSIBLE ADULT BEFORE NOTARY REQUIRED

State of County of

I, _____, a Notary Public for said County and State, do hereby certify that _____ personally appeared before me this day and acknowledge the due execution of the foregoing instrument. Witness my hand and official seal, this _____ day of _____, 20____.
(official seal)

_____
Notary Public
My commission expires :