



GULF STATES CONFERENCE MEDICAL RECORD/CONSENT FORM

_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Full Name	DOB	Phone	Age	M	F
_____	_____	_____			
Address	City / State	Zip			

Home Phone: _____ Legal Guardian: _____

Father's Name: _____ Father's Work Phone: _____

Mother's Name: _____ Mother's Work Phone: _____

Family Physician: _____ Office Phone: _____

Medical Insurance: _____ Company: _____

Insurance Policy Number: _____

Does your Child have any allergies? (i.e. food, medications, insect bites, hay fever, etc.) Y ☐ N ☐

Has your Child ever been hospitalized? Y ☐ N ☐ If so, when? For what? _____

Does Your Child have a History of any of the following?

- ☐ Heart Disease
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Anemia

- ☐ Immune Deficiency
- ☐ Shortness of Breath
- ☐ Cancer
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Heart Murmur

- ☐ Seizures/Convulsions
- ☐ Emotional Disorders
- ☐ Thyroid Problems
- ☐ Hyperactivity
- ☐ Bleeding/Hemophilia
- ☐ Back Problems

Is there any reason to restrict full activity, including, but not limited to swimming, hiking, or strenuous physical activity? Y ☐ N ☐

Does your child have any medical conditions not covered above? **Y** ☐ **N** ☐

Is your child taking any medications at present? **Y** ☐ **N** ☐

I, on behalf of myself, my spouse, next of kin, executors, heirs, assigns, or anyone else who might claim or sue on my or my child's behalf, fully release and agree not to sue the GSC of Seventh-Day Adventists and any of its agents, employees, and/or volunteers from any and all liability, including but not limited to any claims, losses, or liabilities due to death, personal injury, disability, property damage, medical expenses, and/or theft, that may arise from or relate to my child's participation in the event, including transportation to and from the event and any provision of medical care in case of an emergency, I hereby give permission to the physician selected by the club directors to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for my child. I understand that every reasonable effort will be made to contact me.

The information given by me on this form is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities, except as noted by me.

Parent/Guardian Name

Relation to Child

Date