Medical/Insurance Information
& Contact Information
2007/2008

Please print:

Name: ____________________________ Grade: ___ Age: ___ M/F: ___

Address: ____

Home Phone: __________ Cell Phone(s): ____________________________

Parent's Names: ____

Work Phone: (Mother) _________________ (Father) _________________

In case of emergency, contact: **_____________________________________**

Relation to youth: ___________________ Phone: ____________________

Prescriptions taken: ____

Allergies/Special Needs: ____

Directions for administering medication: ____________________________

Physician's name: __________________________ Phone: _____________

Insurance carrier, group #, etc. ____________________________________

Parents' Authorization: The person herein described has permission to participate in all prescribed youth activities except as noted by me or by our physician for all Westminster youth events for the year 2006/2007.

I hereby give permission for the physician/hospital selected by the Westminster Youth Director or youth volunteer to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission for the physician selected to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child as named above.

Parent signature:______________________________ Date: _______________

I, the undersigned Notary Public, attest that the Parent/Guardian who signed above did personally stand before me.

Notary Signature: _____________________________ Date: _________

My Commission Expires____________________________