

Spotswood Baptist Church
4009 Lafayette Blvd.
Fredericksburg, VA 22408
540-898-0757

**2008/2009
Medical Information**

Youth Name: _____

Birthdate: _____ Parent's Name: _____

Emergency Contact Numbers: Home _____ Cell # & Name _____

Cell # & Name _____ Work # & Name _____

Doctor's Name and Phone number: _____

Insurance Company: _____

Policy/Group #: _____

Please list any health/medical conditions your youth/child has: _____

Does he/she have any allergies? Please list... _____

Does he/she have any drug allergies? Please list... _____

Is your son/daughter currently on any medications? Please list name, dose and schedule...
_____ Your child will be
responsible for administering his/her own medications.

Copy of insurance card must accompany this form.

I give consent for my child to receive over the counter medications. Initial _____

Signature of Parent or Guardian:

Date:

**IF THERE ARE ANY CHANGES MADE DURING THE YEAR A
NEW FORM WILL NEED TO BE FILLED OUT.
PLEASE CONTACT US FOR THE FORM**

Please initial if you authorize Spotswood BC to include pictures of this student on the church website and in printed material. First names only will appear in any picture descriptions.