

## ACTS Emergency Medical Form

Last Name \_\_\_\_\_ Mother's First Name \_\_\_\_\_ Father's First Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Father's Work/Cell # \_\_\_\_\_ Mother's Work/Cell # \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Doctor's Phone \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone \_\_\_\_\_ Policy # \_\_\_\_\_ Policy Group \_\_\_\_\_

### Participating Children and Parents (Use back of page if more room is needed):

Name \_\_\_\_\_ Any medical conditions/allergies? \_\_\_\_\_

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Name \_\_\_\_\_ Any medical conditions/allergies? \_\_\_\_\_

Name \_\_\_\_\_ Any medical conditions/allergies? \_\_\_\_\_

### Consent: Please read and sign below.

In the event that I or other contact persons are unable to be reached, I authorize ACTS or Rocky Mountain Calvary Church personnel to consent to necessary medical treatment recommended by a medical professional at no expense to ACTS or the Rocky Mountain Calvary Church.

\_\_\_\_\_  
Parent's or Guardian's Signature

\_\_\_\_\_  
Date