ACTS Emergency Medical Form

Last Name_____	Father's Name_____	Mother's Name_____
	Cell_____	Cell_____
Emergency Contact_____	Emergency Contact Phone_____	

Medical Information

Doctor's Name_____	Phone_____	Preferred Hospital_____	
Insurance_____	Phone_____	Policy #_____	Policy Group_____

Participating Children and Parents (please use back of page if more space is needed):

Name_____	Medical Conditions/Allergies_____
Name_____	Medical Conditions/Allergies_____
Name_____	Medical Conditions/Allergies_____
Name_____	Medical Conditions/Allergies_____
Name_____	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 Rocky Mountain Calvary Church.

_____ _____

Signature Date