



**CEDAR ROCK FIRST BAPTIST CHURCH**  
**General Medical Information**

Name of the Activity or Event: \_\_\_\_\_

Date of Activity or Event: \_\_\_\_\_

Name \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F  
(last) (first) (initial)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

**MEDICAL STATEMENT**

*(All information requested below must be filled out before participant can take part in the above named event.)*

a. General Health: \_\_\_\_\_

b. Limitations: \_\_\_\_\_

c. Are you subject to:  Diabetes  Epilepsy  Heart Disease  Hypertension  Other: \_\_\_\_\_

d. Appendix removed?  Yes  No Tetanus shot updated?  Yes  No

e. Medicine taken: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_ Reason: \_\_\_\_\_

f. Allergies (food, drugs, other): \_\_\_\_\_

Medications used to treat allergies: \_\_\_\_\_

g. Medical treatment received in the past year: \_\_\_\_\_

h. Have you had or been exposed to a contagious disease in the past six months?  No  Yes \_\_\_\_\_  
(Describe)

Physician's Name: \_\_\_\_\_ Office phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**CONSENT**

I hereby give permission for my  Son  Daughter  Self (if over 18 years of age) to receive emergency medical attention from a physician in the event of illness or injury:

\_\_\_\_\_  
Print Participant's Name Age Signature (if under 18 years old, Date  
Parent or guardian must also sign)

**INSURANCE**

Insurance issued in the name of \_\_\_\_\_

Address of insured: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_

Address of insurance company \_\_\_\_\_

\_\_\_\_\_ Policy Number: \_\_\_\_\_