



FIRST BAPTIST CHURCH  
**AUTHENTIC YOUTH MINISTRY**  
 CONSENTIMIENTO MEDICO  
 Phone # (903) 675-5135 Fax # (903) 675-4708

NOMBRE (completo) DEL ESTUDIANTE: \_\_\_\_\_

TELEFONO DEL ESTUDIANTE: \_\_\_\_\_

DIRECCION: \_\_\_\_\_

NOMBRE DEL PADRE/MADRE: \_\_\_\_\_

CORREO ELECTRONICO: \_\_\_\_\_

TELEFONO: \_\_\_\_\_ MOBIL: \_\_\_\_\_

GRADO: \_\_\_\_\_ ESCUELA: \_\_\_\_\_ EDAD: \_\_\_\_\_ FECHA DE NACIMIENTO: \_\_\_\_\_

**LA LEY REQUIRE LA SIGUIENTE INFORMACION DE CADA PERSONA.**

SEGURO MEDICO: _____ I.D. #: _____ (NECESITO UNA COPIA) DIRECCION: _____ CODIGO POSTAL: _____ NO. TELEFONO: _____ Por este medio autorizo que (nombre del estudiante), _____ reciba cuidado medico y, de ser necesatio, hospitalizacion. El estudiante sera llevado al hospital y sera atendido por los doctores. FIRMA: _____ NO. TELEFONO: _____
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SI EL PADRE O LA MADRE NO ESTAN DISPONIBLES, ¿CON QUIEN PODEMOS COMUNICARNOS?:

1. \_\_\_\_\_ TELEFONO: \_\_\_\_\_

2. \_\_\_\_\_ TELEFONO: \_\_\_\_\_

MEDICO DE LA FAMILIA: \_\_\_\_\_ TELEFONO: \_\_\_\_\_

¿ALERGIAS?: \_\_\_\_\_

¿ALERGIAS A ALGUN MEDICAMENTO? \_\_\_\_\_ CUALES: \_\_\_\_\_

¿ESTA TOMANOD ALGUN MEDICAMENTO?: \_\_\_\_\_

¿ALGUNA VEZ HA SIDO DIAGNOSTICADO CON ALGUNAS DE LAS SIGUIENTE CONDICIONES?:

\_\_\_ DIABETES \_\_\_ EPILEPSIA \_\_\_ ASMA \_\_\_ PROBLEMAS CARDIACOS \_\_\_ PROBLEMAS DE TIROIDE \_\_\_ FIEBRE REUMATICA

SI LA RESPUESTA HA SIDO “SI” A ALGUNA CONDICION, DE MAS DETALLES: \_\_\_\_\_



FIRST BAPTIST CHURCH  
**AUTHENTIC YOUTH MINISTRY**

**MEDICAL RELEASE FORM**

Phone # (903) 675-5135 Fax # (903) 675-4708

STUDENTS (full) NAME: \_\_\_\_\_

STUDENTS PHONE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PARENT OR GUARDIAN: \_\_\_\_\_

ADDRESS (IF DIFFERENT FROM ABOVE): \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

HOME/CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

GRADE LEVEL: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

*STATE LAW REQUIRES THE BELOW INFORMATION ON EVERYONE.*

INSURANCE COMPANY: \_\_\_\_\_ I.D. #: \_\_\_\_\_  
(NEED COPY)

ADDRESS: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_ PHONE: \_\_\_\_\_

I hereby authorize (student's name) \_\_\_\_\_ to obtain medical care and services as well as hospitalization, if necessary, and that he/she will be taken to a local hospital and will be attended by a physician on call there.

SIGNATURE: \_\_\_\_\_ PHONE: \_\_\_\_\_

CONTACT PERSONS IF PARENT/GUARDIAN IS NOT AVAILABLE:

1. \_\_\_\_\_ PHONE: \_\_\_\_\_

2. \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATION? \_\_\_\_\_ SO, PLEASE LIST BELOW: \_\_\_\_\_

MEDICATION YOU ARE CURRENTLY TAKING: \_\_\_\_\_

HAVE YOU EVER BEEN TOLD YOU HAD ANY OF THE FOLLOWING?:

DIABETES  EPILEPSY  ASTHMA  HEART TROUBLE  THYROID TROUBLE  RHEUMATIC FEVER

IF THE ANSWER TO ANY OF THESE CONDITIONS IS YES, PLEASE EXPLAIN: \_\_\_\_\_

**NOTES: PARENTS WILL BE CONTACTED IF THERE ARE MEDICAL PROBLEMS.**

This form can be faxed to the Student Ministry at (903) 675-4708 or e-mailed to [scott@authenticyouth.com](mailto:scott@authenticyouth.com)