



**Southwood Church of the Nazarene  
YOUTH MEDICAL CONSENT FORM**  
(This form must be on file in order for individual to participate)

NAME \_\_\_\_\_ DOB \_\_\_\_\_

MALE/FEMALE \_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**Emergency Contact # 1 (First Contact)**

NAME \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**Emergency Contact # 2 (Second Contact)**

NAME \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**Youth History:**

Medical Information (e. g. asthma, diabetes, seizures, etc.) \_\_\_\_\_

Medications currently taken on a regular or "as-needed" basis. List reasons for use and dosage schedule:

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Known Allergies? \_\_\_ Yes \_\_\_ No To what? Please specify \_\_\_\_\_

Significant Injury / illness within past year (e.g. mono, broken bone) \_\_\_\_\_

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Date of last physical exam \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

Other medically related comments:

**Insurance Company** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Policy Holder** \_\_\_\_\_ **Policy Number** \_\_\_\_\_

If possible, please photocopy insurance card and attach to this form.

**Consent/Authorization:** Permission for Emergency Treatment

In the event I am unable to make rational decisions regarding my medical care and my emergency contacts cannot be reached, or if the delay may cause serious danger to me, I authorize medical and/or surgical treatment as may be deemed necessary or advisable. I also authorize the release of medical information to insurance companies for the purpose of payment, and to health care providers who may treat me.

Signature \_\_\_\_\_ Date \_\_\_\_\_