

**Health Form
Community Presbyterian Church
39 North Prospect Avenue
Clarendon Hills, IL 60514
630-323-6522**

Name _____ Phone _____

Address _____ Town & Zip _____

Date of Birth _____

Family Medical Insurance (Include company and policy and/or group number)

_____ Please include a photocopy of the back and front of your insurance card

Medical Conditions _____

Allergies _____

Current medications (include over-the-counter medication and contact lenses)

PERSONS TO CONTACT IN AN EMERGENCY:

Parent or Guardian _____

Address, if different _____

Home phone _____ Work or cell phone _____

Alternate Contact _____

Relationship _____

Address _____

Home phone _____ Work or cell phone _____

Alternate Contact _____

Relationship _____

Address _____

Home phone _____ Work or cell phone _____

In consideration of the benefits derived from participation, we hereby voluntarily waive any claim against Community Presbyterian Church, Clarendon Hills, Illinois, or its staff and advisors for any and all causes which may arise in connection with this activity.

I, who by law may do so, authorize the administration of emergency medical treatment to s/he who is subject to this form. I understand that in the event medical intervention is needed, every attempt will be made to contact the person(s) above immediately.

Date _____ Signed (one parent or guardian) _____