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**_____

PLEASE ALSO INCLUDE AN ALTERNATE CONTACT OTHER THAN A PARENT

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)**_____

(Revised 2/2016)