VINEWOOD COMMUNITY CHURCH

1900 WEST VINE ST., LODI, CA 95242
209.369.1068

ANNUAL HEALTH FORM

Today's Date _____ // _____ // _____

Minor's/Leader's Name _____ Date of Birth _____ Grade _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

Sex _____ Height _____ Weight _____

INSURANCE AND DOCTOR INFORMATION

Insurance Company _____

Policy Number _____ Group Number _____

Name Listed on Policy _____ Insurance Phone Number _____

Doctor's Name _____ Phone _____

Address _____ City, State _____ Zip _____

Dentist's Name _____ Phone _____

Address _____ City, State _____ Zip _____

HEALTH INFORMATION

Please list current medications taken by minor and dosage: _____

_____

Please list any known pre-existing conditions: _____

_____

Please list all known allergies: _____

Date of last tetanus shot? _____

Does minor wear contact lenses? _____ Eye glasses? _____

List any known restrictions or other special physical dietary needs: _____

_____

PLEASE COMPLETE REVERSE SIDE. THANK YOU.

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CONTACT INFORMATION / EMERGENCY CONTACT

Parent/Guardian Name _____ Address _____

Phone Numbers - Home _____ Cell _____ Work _____

Email Address _____

Backup Contact _____ Address _____

Phone Numbers - Home _____ Cell _____ Work _____

Parent/Guardian Signature _____ **Date Completed** _____

FOR STUDENTS - Parent/Guardian Consent to Treat a Minor

Being the parent or legal guardian of _____, I, _____, do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care. Further, as parent or legal guardian I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care treatment that is given to my child. Any policy of Vinewood Community Church sponsoring this event will be used as the secondary coverage.

Parent/Guardian Signature _____ **Date** _____

FOR LEADERS - Consent to Treat Agreement

I, _____, do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for myself. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat myself. I further understand that the doctors, dentists, and other providers attending to myself will take all reasonable safety precautions during their care. Further, I agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care treatment that is given and I will pay for any costs outside of the insurance coverage. However, any policy of Vinewood Community Church sponsoring this event will be used as the secondary coverage.

Signature _____ **Date** _____

PLEASE COMPLETE REVERSE SIDE. THANK YOU.