

**Remembrance Church 56 FROGs  
Sept. 1, 2009 – Sept. 1, 2010  
Health Information**

Name: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_

City State Zip  
E-Mail Address: \_\_\_\_\_  
Parent's: \_\_\_\_\_  
Child's: \_\_\_\_\_

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Parent/Legal Guardian: \_\_\_\_\_

Father's Name: \_\_\_\_\_  
Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell: \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell: \_\_\_\_\_

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Insurance Provider:  
Name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

Doctor: Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_  
Medications being taken: \_\_\_\_\_  
Physical conditions that we should be made aware of:  
\_\_\_\_\_

Current tetanus shot?  No  Yes Date: \_\_\_\_\_

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School: \_\_\_\_\_ Grade: \_\_\_\_\_

**Permission To Treat Minor Child**

I, \_\_\_\_\_, the parent having legal custody, or the legal guardian of \_\_\_\_\_, a minor, have given my permission for him/her to participate in the Remembrance Reformed Church 56 FROGs activities from 9/1/09 – 9/1/10, which include but are not limited to:

On site and Off site events for the 56 FROGs Program  
Post Farm Pando Service Projects

In the event that he/she is injured and requires the care of a doctor, we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is called for which a physician and/or hospital personnel refuse to administer without our consent, we hereby authorize the following Remembrance Church adult leaders to give such consent for us if we cannot be reached by telephone at one of the numbers indicated on the reverse or because of an emergency there is not time or opportunity to make a telephone call:

Justin Palmer Melissa Palmer Jennifer Bakhuyzen

In the event it becomes necessary for that person to give consent for us, we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician.

\_\_\_\_\_  
Signature of parent or legal guardian Date