MOMS Medical Form

2019-2020

Office Use Only

Date Accepted________________
Staff Initial________________

Please print and do not leave any questions blank. If they do not pertain to the participant, please write N/A. Incomplete forms will be returned to the parent/guardian for completion. Without a copy of both sides of the insurance card, this document is considered incomplete. This form cannot be scanned or emailed.

First Name: __________________________ Last Name: ___________________________ Date: _____________

Gender: _________________ DOB (MM/DD/YYYY): ______________________________

Address: ____

Home Phone: _____________________________________ Cell Phone: ________________________________

Email Address: ____

Primary Physician Full Name: ____

Primary Physician Phone Number: ____

Dentist Full Name: ____

Dentist Phone Number: ____

Date of Last Tetanus Shot (MM/DD/YYYY): _________________________ (if unknown, write unknown)

Taking Any Medications Currently (use separate sheet if necessary, include epipen & inhaler)? Yes ___ No ___

Name of Drug	Dosage	Time medication taken

Any Medication Allergies? Yes ___ No ___

Name of Drug	Reaction	Treatment

Any Food Allergies? Yes ___ No ___

Name of Food	Reaction	Treatment

Any Environmental Allergies? Yes ___ No ___

Name of Allergen (ex. grass)	Reaction	Treatment

Please complete the back of form

Does the participant have Asthma? Yes ___ No ___

Cause of Trigger	Reaction	Treatment

Does the participant carry a Rescue Inhaler with them at all time? Yes ___ No ___

Does the participant carry an EpiPen with them at all time? Yes ___ No ___

Does the participant have a physical and/or psychological ailment, illness, weakness, limitation, handicap, disability condition or diagnosis found on the autism spectrum that the La Casa staff or leaders should know about?
Yes ___ No ___ If yes, please explain in detail: ____
____
____

Insurance Information

Please provide us a copy of your insurance card, front and back. (Copy can be made at church or emailed to julibarri@lacasadecristo.com)

Name of Primary Insured: ________________________________ If no insurance, ________ (initial)

Name of Employer: ________________________________

Parent/Guardian Information

Mother/Guardian

Full Name: ____________________________

Address: ____________________________

City, State, Zipcode: ____________________________

Preferred Phone Number: ____________________________

Work Phone Number: ____________________________

Email Address: ____________________________

Father/Guardian

Full Name: ____________________________

Address: ____________________________

City, State, Zipcode: ____________________________

Preferred Phone Number: ____________________________

Work Phone Number: ____________________________

Email Address: ____________________________

Emergency Contact Information

If we cannot contact a parent/guardian in case of an EMERGENCY, please list 2 adults we should contact.

Full Name: ____________________________

Address: ____________________________

City, State, Zipcode: ____________________________

Preferred Phone Number: ____________________________

Relationship: ____________________________

Full Name: ____________________________

Address: ____________________________

City, State, Zipcode: ____________________________

Preferred Phone Number: ____________________________

Relationship: ____________________________

I understand that I must provide a copy of both sides of the insurance card. ____________ (initial)

I release and discharge La Casa de Cristo, its volunteers, and staff from any and all liability in connection with accidents or injuries that occur, regardless of the cause. I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under general or special supervision and upon the advice of or to be rendered by a licensed physician, surgeon, and/or dentist. I further agree to pay all charges for dental, medical, and/or hospital care or treatment. I am responsible for the health care decisions and am authorized to consent to the services to be rendered.

Signature: ____ **Date:** ________________