La Casa de Cristo
LUTHERAN CHURCH

MarriedPeople 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:** _____