

**Note: Please attach photocopy of medical insurance provider card.**

I, \_\_\_\_\_,  
*(Parent / Guardian)* give leadership representatives of Christian Communicators of Pennsylvania (CCofPA) permission to obtain emergency medical treatment for my child, \_\_\_\_\_,  
*(Student)* while participating in any activity event attended by CCofPA. I will be responsible for any medical costs incurred.

\_\_\_\_\_  
*Parent / Guardian Signature*

\_\_\_\_\_  
*Date*

Please list any food, animal, or environmental allergies: \_\_\_\_\_

Please list any allergies to medications: \_\_\_\_\_

Is this student asthmatic? (List symptoms of attack)  No  Yes \_\_\_\_\_

If so, does the student carry an inhaler or meds?  No  Yes \_\_\_\_\_

Does this student wear contact lenses? (Type)  No  Yes \_\_\_\_\_

Does this student have a chronic disease? (Explain)  No  Yes \_\_\_\_\_

If so, does the student take medications for it?  No  Yes \_\_\_\_\_

Is there any other medical information you would like us to know? \_\_\_\_\_

**EMERGENCY CONTACTS**

Name & Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name & Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Provider \_\_\_\_\_ Policy # \_\_\_\_\_