Faith Bible Fellowship Church
Harleysville, PA

Health Form
valid: July 2008 through July 2009

Last Name:_____________________ First & Middle Name: __________________
Street Address:____ Age:____
City, State, Zip:____

Medical Insurance Co.:____
Policy #:_________________________ Group :____________________________

List any Medical Conditions:____
____
____

List any Allergies (especially to
medications):_______________________________
____
____

List any Current Medications (include prescriptions & over-the-counter items):___
____
____

Does your child wear contact lenses? Yes / No

Name of Parent or Guardian:____
Mailing Address (if different):____
____
Home Phone ( ) ______-__________ Work Phone ( )_____-_________

Name of alternate person to contact (should live near person named above):___
____
Street Address:____
City, State, Zip:____
Home Phone: ( )_______-_________ Work Phone ( ) ____-_________

I, who by law may do so, authorize the admission of emergency medical treatment to the subject of this form. I understand all reasonable safety precautions will be taken at all times by Faith Bible Fellowship Church of Harleysville and its agents liable for any accident, injury or disease incurred by the subject of this form. I understand that in the event that medical intervention is needed, every attempt will be made to contact the person(s) above immediately.

Signature of Parent/Guardian or Subject (If 18 or older)

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