FBC CLARKS COMMUNITY DAY PROGRAM
HEALTH & POWER OF ATTORNEY FORM

Name	Birth Date	( ) M ( ) F
Address City State Zip		
Weeks Attending	Dates	Grade in Fall
Mother's (Guardian's) Name	Father's (Guardian's) Name	
Address if different than above	Address if different than above	
Home (_____) _____ Work (_____) _____ Cell (_____) _____	Home (_____) _____ Work (_____) _____ Cell (_____) _____	
Other Emergency Contact Phone		
Physician Name Phone		
Insurance Company & Policy # Participant(s) SS #		

IMMUNIZATIONS

- ☐ Diphtheria
- ☐ Whooping Cough
- ☐ Polio
- ☐ MMR
- ☐ Tetanus ____/_____/_____

ALLERGIES /

- ☐ Asthma
- ☐ Epilepsy
- ☐ Heart
- ☐ Recent Surgery: _____
- ☐ Other: _____

CONDITIONS

- ☐ Fainting
- ☐ Seizures
- ☐ Sleep Walking

_____

_____

ILLNESSES

In the last two weeks

- ☐ Flu
- ☐ Sore Throat
- ☐ Chicken Pox
- ☐ Other _____

Other precautions, medical conditions, or medications (with directions): _____

LIMITED POWER OF ATTORNEY: CONSENT OF TREATMENT OF MINOR AND RELEASE OF LIABILITY

I/We, the undersigned, hereby appoint the First Baptist Church (FBC) Clarks Grove and each of its authorized agents, each to act alone, and to delegate to the same power to consent on our behalf to all emergency treatment and/or any medical care (except elective surgery) of (child(ren) name) _____ determined to be necessary or desirable by our child's attending physician at the hospital in which emergency treatment and/or medical care is sought.

I/We, the undersigned, give permission to FBC Clarks Grove and each of its authorized agents to administer over-the-counter medication to (child(ren) name) _____ should this be deemed necessary. Additionally, all physicians-prescribed medications will be dispensed to the camper only if the prescription is contained in its original prescription bottle and only for the exact dosage prescribed on the bottle by the physician.

This Power of Attorney shall continue until revoked by the undersigned, or for one (1) year after its date, whichever is earlier. The attending physician(s) or the attending hospital's medical staff may assume and rely that this authorization is currently in effect during such one (1) year unless notified.

I/We, the undersigned, release FBC Clarks Grove and any of its authorized agents from any obligation or liability, actual or implied, concerning their use of the limited purpose power of attorney.

The undersigned certify that they have read the Power of Attorney and Release of Liability For (or had it read to them) and that they understand the same:

Parent/or Legal Guardian's Signature_____ Date:_____

Witness' Signature_____ Date:_____

Witness' Address:_____ City_____ State_____ Zip_____

Witness' Home Phone: Night Other