

# FBC CLARKS GROVE – COMMUNITY DAY PROGRAM HEALTH & POWER OF ATTORNEY FORM

Name	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address City State Zip		
Email Address		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 # SS #		

<b>IMMUNIZATIONS</b>	<b>ALLERGIES / CONDITIONS</b>	
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Seizures
<input type="checkbox"/> Polio	<input type="checkbox"/> Heart	
<input type="checkbox"/> MMR	<input type="checkbox"/> Recent Surgery: _____	
<input type="checkbox"/> Tetanus ___/___/___	<input type="checkbox"/> Other: _____	

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

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

1. 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 (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.

2. 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.

3. 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.

4. 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: \_\_\_\_\_