

Medicine Form: Briarcliff Church

Participant Name: _____

Participant Age: _____ Participant Gender: _____ Male _____ Female

Emergency Contact Information:

Parent/Guardian Name: _____

Parent/Guardian Cell Phone Number: _____

Secondary Contact Name: _____

Secondary Contact Cell Phone Number: _____

Medical Profile

In general, participant's health is: _____ Excellent _____ Good _____ Fair _____ Poor

Explain: _____

Current medical needs being treated for:

Please note any medical history to be aware of:

Medication(s) that this Participant Currently Takes/Needs and instructions on administering:

Any allergies: _____

Special Diet: _____

Primary Physician: _____ Phone: (_____) _____

I authorize _____ Church staff to give my child the medication(s) indicated above.

Signature of Parent/Guardian:
