Southside Baptist Church
1356 Pineland Drive
Florence, SC 29505
(843) 669-7288

Authorization for Medical Treatment (ADULT)

DATE: _____

TO WHOM IT MAY CONCERN:

I _____, hereby give my consent to any emergency facility and/or physician to administer necessary treatment to me in the event of an emergency and I give consent to transport by ambulance if the situation warrants.

I understand that I will be responsible for administering ANY PRESCRIPTION MEDICATION while on any trip and I will be financially responsible for any medical care. I understand that this medical authorization is effective from JANUARY 1, _____ (current year) to JANUARY 31, _____ (next year).

I understand that I am responsible for notifying Southside Baptist Church of any changes in my medical conditions and/or information during the above effective dates.

NAME: _____D.O.B. _____AGE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
NAME OF FAMILY PHYSICIAN: _____ PHONE: _____
ALLERGIES: _____
LAST MEDICAL ATTENTION: TYPE: _____ DATE: _____ PHYSICIAN: _____
DATE OF LAST DPT OR TETANUS: _____
NAME OF INSURANCE COMPANY (MEDICAL): _____
POLICY #: _____ EXPIRATION DATE: _____

EMERGENCY PHONE NUMBERS:

PERSON TO CONTACT: _____ WORK#: _____HOME#: _____
PLACE OF EMPLOYMENT: _____RELATIONSHIP: _____

FAMILY MEDICAL HISTORY: Has any blood relative ever had any of the medical conditions listed below? Please check the correct response. (Please leave nothing blank)

Medical Condition	Yes	No	Medical Condition	Yes	No	Medical Condition	Yes	No
Cancer			Diabetes			High Blood Pressure		
Tuberculosis			Kidney Disease			Stroke		
Epilepsy			Heart Trouble			Bleeding Disease		
Other:			Other:			Other:		

Please complete back also.

SERIOUS INJURIES: (Such as concussion, fracture, etc.) Please list below. I none, please write "NONE" across the table below.

Type of Injury	Date	Physician	Physician Phone #

PERSONAL MEDICAL HISTORY: Have you ever had any of the medical conditions listed below? Please check the correct response.

Medical Condition	Yes	No	Medical Condition	Yes	No	Medical Condition	Yes	No
In the past ten years have you had a PPD (TB Skin Test)			In the past ten years have you had a Tetanus Shot			Other: _____ _____		
Red Measles			German Measles			Mumps		
Whooping Cough			Diphtheria			Small Pox		
Chicken Pox			Typhoid Fever			Influenza		
Pneumonia			Scarlet Fever			Tuberculosis		
Polio			Meningitis			Asthma		

ALLERGIES: If you have any of the allergies below, please check the correct response. (Please leave nothing blank)

Allergy	Yes	No	Reaction (If Yes)	Allergy	Yes	No	Reaction (If Yes)
Penicillin				Eggs			
Sulfa				Insect Bites			
Barbiturates				Other Allergy			

PREVIOUS SURGERGIES: Please list below. If none, please write "None" across the table.

Previous Surgeries	Date	Physician	Physician Phone #

PREVIOUS HOSPITALIZATIONS: Please list below. If none, please write "None" across the table.

Previous Hospitalizations	Date	Physician	Physician Phone #

Signature: _____

NOTARIZATION REQUIRED:

Witness my hand and official seal, this _____ day of _____ A.D. _____

My commission expires: _____

Notary Public _____ State of South Carolina at large, County of _____