

# QUAIL LAKES BAPTIST CHURCH

1904 Quail Lakes Dr., Stockton, CA 95207  
(209)951-7380

## Annual Health Form for a Minor

(This form is valid June 1, 2022 through May 31, 2023.)

Minor's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade in **Fall 2022** \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

### INSURANCE AND DOCTOR INFORMATION

Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name Listed on Policy \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

### HEALTH INFORMATION

Please list current medications taken by minor and dosage: \_\_\_\_\_

\_\_\_\_\_

Please list any known pre-existing conditions: \_\_\_\_\_

\_\_\_\_\_

Please list all known allergies: \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Does minor wear contact lenses? \_\_\_\_\_ Eye glasses? \_\_\_\_\_

List any known restrictions or other special physical/dietary needs: \_\_\_\_\_

\_\_\_\_\_

### CONTACT INFORMATION

Parent/Guardian Name \_\_\_\_\_ Address \_\_\_\_\_

Phone Numbers - Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email Address \_\_\_\_\_

Backup Contact \_\_\_\_\_ Address \_\_\_\_\_

Phone Numbers - Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date Completed \_\_\_\_\_

**PLEASE COMPLETE REVERSE SIDE. THANK YOU.**

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## Parent/Guardian Consent to Treat a Minor

(This form is valid June 1, 2022 through May 31, 2023.)

Being the parent or legal guardian of \_\_\_\_\_, I, \_\_\_\_\_,  
(MINOR'S FIRST & LAST NAMES PRINTED) ( PARENT/GUARDIAN'S FIRST & LAST NAMES PRINTED)  
do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care treatment that is given to my child. Any policy of Quail Lakes Baptist Church sponsoring this event will be used as the secondary coverage.

Minor's Date of Birth \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_