

EMERGENCY MEDICAL INFORMATION

BREAKER ROCK BEACH VBS- 2024

Student Name:_____ Home Phone Number:_____

Father:_____ Mother:_____

Email:_____ Email:_____

Work #:_____ Cell#:_____

Work #:_____ Cell#:_____

My Child may be given the following medication by Rock of Salvation Church (“ROSC”)

Personnel:

_____ Tylenol _____ Cough Drops _____ Pepto Bismol

Date of Last Tetanus Shot:_____ Is your child currently taking any medication?_____

If yes,

Please Explain:_____

Is he/she allergic to any medication?_____ If yes, please explain_____

Is he/she allergic to Bee Stings?_____ If yes, Please explain:_____

Does he/she have any physical injuries, past or present? (Allergies, physical limitations, health conditions?)

Primary Care Physician:_____

Phone:_____



Rock of Salvation Church

159 Dixon Rd., Milpitas, CA-95035

Phone: (408) 834-8910

E-mail : vbsinfo@rockosc.org

www.rockosc.org

Specialist: _____

Phone: _____

Dentist: _____

Phone: _____

Insurance Company: _____ Policy#: _____

I agree not to sue or hold ROSC liable for any medical decision made under emergency circumstances when I or my emergency contacts cannot be reached. I authorize ROSC to seek emergency medical treatment on behalf of my child in the event of sickness or an injury at my expense. I hereby give permission to the physician selected by the church to order X-rays, routine tests, and secure proper treatment, hospitalize, and to order injections/and/or anesthesia and/or surgery and emergency treatment for my child as named on this form.

Please list contact (including parents) should an emergency arise:

1. Name _____ Number _____

2. Name _____ Number _____

3. Name _____ Number _____

Statement of Cooperation: I give permission for my child to take part in all activities, including sports and trips away from the church premises, and absolve the church from liability to me or my child because of any injury to my child during any VBS activity.

Parent/Guardian’s Signature: _____

Date: _____

Parent/Guardian’s Signature: _____

Date: _____



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