Yorkfield Presbyterian Church
Youth Fellowship
1099 South York Road
Elmhurst, IL 60126

Medical Information Form

______________________ ______________________ ____/____/____
(Student First Name) (Student Last Name) (Student Birthdate)

____
(Address: Street/City/State/ZIP)

Allergies:	
Medications:	
Other Needs	
Regular Doctor:	Doctor Phone:
Insurance Carrier:	Primary Insured:
Group #	Policy/ID:

I understand that in the event of an emergency, attempts will be made to contact parents and/or secondary emergency contacts. In the event that neither the parents, nor the secondary emergency contacts are available, the Youth Fellowship Coordinator or other supervising adult will provide consent for medical and/or emergency care.

______________________________ ______________
(Parent Signature) (Date)