

Bethel's 2011/12 Sunday School Registration

Please complete one set of forms for each child and place them in the drop box in the back of Fellowship Hall or in the Sunday School Superintendent mailbox outside the Church office. Please return the forms by September 4th.

Child's Name: _____

Address: _____ Phone: _____

Birth Date: _____ Sex: _____ School Grade: _____

Special concerns: _____

Parents'/Guardians' Names: _____

Phone(s): _____

Can we add your name(s) to our substitute teacher list? Y N Name: _____

Thank you in advance for your help!
This ministry is such an important one for your children.

Sunday School Superintendent Team
Keri Faircloth and Laura Knutsen



Medical History Form (Form #12)

Participant's Name: _____ Birth date: _____

Address: _____

Father's Name: _____ Phone number (s): _____
(or Guardian)

Mother's Name: _____ Phone number (s): _____
(or Guardian)

Physician: _____ Phone number: _____

Dentist: _____ Phone number: _____

Eye doctor: _____ Phone number: _____

Other: _____ Phone number: _____

Participant's current medical condition:

List any prescription and non-prescription medications participant is taking:

Drug sensitivity and allergies (describe): _____

Name of health insurance carrier: _____ Group #: _____

Has the participant ever had one of the following?

- Lung disorder.....yes/ no
- High blood pressureyes/ no
- Heart troubleyes/ no
- Nervous disorderyes/ no
- Disease or disorder of the digestive tractyes/ no
- Any form of canceryes/ no
- Disease of the kidneyyes/ no
- Diabetesyes/ no
- Arthritisyes/ no
- Hepatitisyes/ no
- Malariayes/ no

Disease or disorder of the blood? (describe) _____

Any physical defect or deformity? (describe) _____

Any vision or hearing disorders? (describe) _____

Any life-threatening conditions? (describe) _____

Any contagious disorders? (describe) _____

Has the participant been treated by a physician or been disabled or hospitalized during the last year? (describe) _____

Have the participant had or been advised to have a surgical operation within the last five years? (describe) _____

Date of last physical: _____ Date of last tetanus shot _____

Family history (List important medical problems):

Mother:

Father:

Any other special medical information:

Signature of individual completing this form

Printed name

Date Completed