



Discipleship Focus Medical Insurance and Health Authorization Form

In the event of an emergency which requires medical care, I, _____, authorize information regarding my health and care to be shared with my parents/guardian and _____, the Director of Discipleship Focus.

Patient's Full Legal Name:

Last Name _____ First _____ Middle _____

Home Address _____ City _____ State _____ Zip _____

Phone _____ Date of Birth ____/____/____ Social Security Number ____-____-____

Medical Information:

Family Physician _____ Physician's Phone _____

Allergies _____

Date of last Tetanus Shot ____/____/____

Other _____

Parent or Guardian's Full Legal Name:

Last Name _____ First _____ Middle _____

Home Address _____ City _____ State _____ Zip _____

Phone _____ Date of Birth ____/____/____ Social Security Number ____-____-____

Relationship to Student _____ Place of Employment _____

Each person attending Discipleship Focus is required to have medical insurance coverage for the entire length of the program. You may already be covered through your own or your parent's plan. If not, you may apply for short term insurance through Blue Cross Blue Shield of Missouri or Blue Cross Blue Shield of Tennessee depending on which program you are attending.

Insurance Information:

Name of Company: _____ Policy Number: _____

Other Identifying Information: _____ Policy Holder's Name _____

Discipleship Focus Director:

Last Name _____ First _____ Middle _____

Phone _____ Cell _____

(Signature of Parent or Guardian)

(Signature of Participant if of legal age and has own insurance)

Date: _____

Tennessee participants return this form to:
Discipleship Focus
2953 Veterans Blvd
Pigeon Forge, TN 37863

Missouri participants return this form to:
Discipleship Focus
223 Young Life Lane
Branson, MO 65616