Medical Information and Release Form

NAME: _____

First Baptist Church – McMinnville, OR
MEDICAL INFORMATION AND RELEASE FORM

In consideration for being accepted by FIRST BAPTIST CHURCH for participation in ALL CHILDREN/YOUTH TRIPS and ACTIVITIES we, being 21 years of age or older, do for ourselves (myself) (and for and on behalf of my child) do hereby release, forever discharge, and agree to hold harmless First Baptist Church and the directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the child-participant that occurs while said child is participating in the above described trip or activity.

Furthermore, we (I) (and on behalf of our (my) child) hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and work activities involved therein.

If the participant has not attained the age of 21 years:
We (I) are the parent(s) or legal guardian(s) of this participant, and hereby grant our (my) permission for him/ her to participate fully in said trip or activity, and hereby give our (my) permission to take said participant to a doctor or a hospital and hereby authorize medical treatment, including but not in limitation to emergency surgery or medical treatment, and assume the responsibility of all medical bills, if any.

Further, should it be necessary for the participant to return home due to medical reasons, disciplinary action or otherwise, we (I) hereby assume all transportation costs.

PARENTAL PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In the event any child/youth in our care should need emergency medical treatment, we must have your written permission to seek treatment.
Name _____
Date Of Birth _____
Parents/Guardian(S) _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email _____

Emergency Contact Person (Should You Not Be Available)
Name _____ Phone _____

** INFORMATION REQUEST CONTINUES ON BACK **

Name Of Insurance Company_____
Contract/Group No _____

Physician _____ Phone _____
Address _____

Please list any and all allergies; medications, food, environmental, etc.
_____
_____

Please list all medications taken routinely and/or regularly; i.e., medication, dosage, and condition for which taken:
_____
_____

Please list any medical conditions about which we should know: _____
_____

Dates of last Tetanus shot and boosters: _____

I hereby authorize responsible Children/Youth Ministry persons, i.e., Children/Youth Minister and/or designated group leaders, to seek whatever medical help, including surgery, may in their judgment be needed for the above-named person.

Guardians Signature _____ Date _____

*Remember**: Attach front/back copies of insurance card, thank you!***

Guardians please sign and date below at the beginning of each academic year to acknowledge that all of the above information is still accurate.

2016-2017 _____Date_____

2017-2018 _____Date_____

2018-2019 _____Date_____

2019-2020 _____Date_____

2020-2021 _____Date_____