PERMISSION SLIP

I give permission for my child, _____ to participate in various children's/youth activities sponsored by the **First Baptist Church, Quincy, Florida**, during the period of **January 1, 2017 through December 31, 2017**.

I understand that these activities may include transporting my child by bus, car or other means from one location to another and may include amusement park rides and other forms of entertainment which might be available during these activities.

I will not hold the First Baptist Church of Quincy, Inc. or any other sponsor or co-sponsor or any provider of entertainment liable for any injury in which my child might incur.

I hereby give authorization for any emergency medical treatment that might become necessary.

I understand that in the event of professional medical treatment my personal health insurance will provide primary coverage and any additional costs associated with treatment will be my responsibility.

PERMISSION FOR TREATMENT

In case of an accident or illness requiring medical treatment, I authorize treatment for my child, as the attending medical personnel deem appropriate. I agree not to hold the First Baptist Church of Quincy, Inc. responsible for injuries suffered by my child during activities sponsored by the First Baptist Church of Quincy.

DATE _____ _____

SIGNATURE (Parent/Guardian)

State of _____

County of _____

The foregoing instrument was acknowledged before me this _____ day of _____,

20___ by _____, who is personally known to me or who

has presented _____ as identification.

My Commission Expires: (SEAL) _____

SIGNATURE (Notary Public)

_____

NOTARY NAME (Typed or Printed)

VALID JANUARY 1, 2017 THROUGH DECEMBER 31, 2017

Parent fill in the Medical History of your child on the reverse side of this form

MEDICAL HISTORY/PERMISSION FORM

Name_____ Age_____

Address_____ City_____ State_____ Zip_____

In Case of emergency Notify _____ Phone ( )_____

Family Physician _____ Phone ( )_____

Family Insurance Company_____ Policy #_____

Immunizations: ☐ Tetanus ☐ Polio Booster ☐ Measles ☐ Mumps

Other _____

MEDICAL HISTORY

(Check box to give appropriate information)

☐ Asthma ☐ Sinusitis ☐ Bronchitis ☐ Kidney trouble ☐ Diabetes

☐ Heart trouble ☐ Dizziness ☐ Stomach upset ☐ Hay fever ☐ Other

List other conditions:_____

Allergies: Food _____

Penicillin or other drug (name)_____

Insect stings/bites_____

Poison sumac, oak, or ivy_____

Previous operations or serious illnesses_____

_____

Any current medications (list): _____

Special diet (name): _____

Childhood diseases: ☐ Chickenpox ☐ Measles ☐ Mumps ☐ Whooping Cough

Other (list):_____