

# MEDICAL RELEASE FORM

Effective date from January 1, 2018-December 31, 2018

State Street Baptist Church

1420 State Street

Cayce, SC 29033

(803) 796-6123

(Please print in ink)

NAME: \_\_\_\_\_  
(First) (MI) (Last)

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

HOME ADDRESS:

Street/Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

NAME OF MY INSURANCE COMPANY: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ POLICY # \_\_\_\_\_

Plan/Group # \_\_\_\_\_ INSURANCE CO'S PHONE#: \_\_\_\_\_

\*\*\*Please update above information ASAP in the event any of the above information changes.

\*\*\*Please list all medications, allergies, and medical conditions on the back of this form if applicable.

### *Minors Under Age 18 Only*

The above named is a minor under the age of 18. I \_\_\_\_\_,  
(Parent or Legal Guardian Full Name)

give my permission for he/she to go off of State Street Baptist Church grounds under the supervision of an adult leader/chaperone. My emergency contact number is \_\_\_\_\_.

### *All Applicants*

In the event I cannot be reached in a medical emergency, I give the leader(s)/chaperones from State Street Baptist Church permission to seek medical care for the above named, and if necessary to make emergency medical decisions necessary to best preserve his/her health and wellbeing.

\_\_\_\_\_  
(Signature of Parent/Legal Guardian or above named individual over age 18)

\_\_\_\_\_  
(Date signed)

Conditions:

---

---

---

---

---

Allergies:

---

---

---

---

---

Medications:

---

---

---

---

---