

**2017-2018 First Baptist Hanford
Medical Release Form**

PLEASE PRINT

Today's Date: _____

Participant: _____ Child/Jr. High/HS/Adult (circle one)
Address: _____ City: _____ Zip: _____
Birthdate _____ Sex: M _____ F _____ Grade (in fall of 2017) _____
Allergies/medications/medical conditions: _____

Participant: _____ Child/Jr. High/HS/Adult (circle one)
Address: _____ City: _____ Zip: _____
Birthdate _____ Sex: M _____ F _____ Grade (in fall of 2017) _____
Allergies/medications/medical conditions: _____

Participant: _____ Child/Jr. High/HS/Adult (circle one)
Address: _____ City: _____ Zip: _____
Birthdate _____ Sex: M _____ F _____ Grade (in fall of 2017) _____
Allergies/medications/medical conditions: _____

Participant: _____ Child/Jr. High/HS/Adult (circle one)
Address: _____ City: _____ Zip: _____
Birthdate _____ Sex: M _____ F _____ Grade (in fall of 2017) _____
Allergies/medications/medical conditions: _____

CONTACT INFORMATION

Parent/Legal Guardian: _____
(if minor)
Address: _____ City: _____ Zip: _____
Home Phone _____ Work Phone: _____ Cell Phone: _____

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(if minor)
Address: _____ City: _____ Zip: _____
Home Phone _____ Work Phone: _____ Cell Phone: _____

Additional Emergency Contact: _____ Phone: _____

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PLEASE COMPLETE & SIGN BACK SIDE OF FORM

PARTICIPATION & MEDICAL RELEASE

I/we give permission for the above named individual(s) to participate in First Baptist Hanford activities. In the event of an emergency, I understand that an attempt will be made to contact me first. However, if I am unavailable, I authorize First Baptist Hanford and its agents and employees to authorize any and all necessary and appropriate medical treatment for the above named individual(s) for any injuries or conditions suffered by them in connection with said emergency, and I give permission to the attending physician to hospitalize, secure proper treatment and to order the administration of injections, anesthesia or surgery. (Note: Specify any forms of treatment, procedures or medications you do not authorize for the individual(s) indicated above.) I understand this medical release will remain in effect for all FBH activities through the end of May 2018. After that, a new release must be submitted for the current year.

Physician: _____ Phone: _____

Participant or Parent/Legal Guardian Signature: _____ Date: _____

Insurance Carrier: _____ Group/Policy #: _____

Revised: January 10, 2018
FBH Form #002