Lakeside Baptist Church
Adult Medical Release Form

Participant's Name: _____ Date of Birth: _____

Address: _____Today's Date: _____

City: _____ State: _____ Zip: _____

Phone Number: _____E-mail Address: _____

Allergies (food and drug): _____

_____

Do you take any prescription medication(s)?_____If yes, please list:_____

_____

Do you have any notable medical condition(s)?_____If yes, please explain:_____

_____

_____

Name of Medical Insurance Company: _____

Insurance Phone Number:_____ Group Number: _____

Policy Number: _____ Name of Primary Insured: _____

In the event of an emergency where medical treatment is required, I,_____, give my permission to the staff of Lakeside Baptist Church, or adult sponsor, to obtain the services of a licensed physician in the treatment of myself. Furthermore, I hereby assume all risk of said personal injury, sickness, death, damage and expense as a result of participation as above set forth. I further hereby agree to hold harmless and indemnify said organization, Lakeside Baptist Church, its directors, officers, employees and agents, for any liability sustained by said organization as the result of the negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

I grant Lakeside Baptist Church permission to use my name or image in brochures, newsletters, websites, or other materials used to promote the church's ministries.

Participant's Signature: _____