

Xtreme Camp 2017 Contact Form

Please PRINT legibly & fill in ALL blanks. This will be used in case of emergency

STUDENT or SPONSOR SECTION

Last _____ First _____

Age: _____ Date of Birth _____

Male Female Email: _____

Student/Sponsor Cell phone: _____

Address: _____

City _____ State _____ Zip _____

PARENT SECTION & EMERGENCY CONTACT

Parent/Emergency Contact Name: _____

Phone: Home: _____

Cell: _____

Work : _____

Parent email: _____

STUDENT INFO

Any Health Conditions:

Allergies:

Dietary restrictions:

Current medication (send with instructions):

Reason for taking above medication:

Please turn over and complete other side!

RELEASE AND CONSENT TO MEDICAL TREATMENT

STATE OF TEXAS

COUNTY OF COLLIN

I, do hereby consent as an adult sponsor **OR** as Parent or Legal Guardian of _____ to reasonable and necessary medical treatment in the event of the necessity therefore, and I hereby authorize the First Baptist Church of McKinney, through its employees, agents and volunteers, to provide such consent to any health care provider that may require it, sign necessary papers, and in general arrange for reasonable and necessary medical care and treatment that may be necessary.

I further release and forever discharge the First Baptist Church of McKinney, its employees, agents and volunteers of and from any and all claims, demands, damages, actions, causes of action, negligence or suits of any kind or nature, whether heretofore or hereafter accruing, and whether not known, arising out of any activity of the First Baptist Church of McKinney in which my child or myself is a participant.

This Release and Consent shall be valid and binding until revoked by me, in writing, delivered to Grant Byrd, First Baptist Church of McKinney, Texas. I acknowledge that I have read and understand the effect of this Release and Consent to Medical Treatment, and I am executing it for the purposes and considerations set forth.

Parent , Guardian or Adult Sponsor

Dated this _____ day of _____, 2017

Insurance Information:

Carrier: _____

Group Number: _____

Policy Number: _____

Telephone Number of Insurance Company: _____

Please turn over and complete other side!