



FIRST BAPTIST CHURCH
S P A R T A , T N

Medical Release Form/Permission to Treat

Name of Church: _____ City/State: _____
Name: _____ Birthdate: ____/____/____
Age: ____ Gender(M/F): ____
Address: _____
City: _____ State: _____ Zip: _____

Parent/Guardian: _____ Home Phone: (____) _____
Work Phone: (____) _____ Cell Phone: (____) _____
Secondary contact to notify in event of emergency: _____
Their relationship to you: _____ Their phone: (____) _____

Please supply ALL of the following information. Attach a copy of your insurance card. Medical Insurance Co.: _____ Group# _____ Policy#: _____
Company's address: _____ Company's Phone: (____) _____
City: _____ State: _____ Zip: _____
Family Physician's Name: _____ Phone: (____) _____

Physical Limitations (Asthma, diabetes, allergies, etc.), and/or special instructions (Allergic to certain meds, rare blood type, wears contact lenses, etc.):

List ALL medication taken on a regular basis and/or any brought with you to Camp (Prescription meds MUST have a pharmacy label and name of doctor):

List all operations/serious injuries and dates within the past five (5) years:

The Health History is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted.

Emergency Authorization - I hereby give permission to medical personnel selected by the participant's Church sponsor/his designee or camp staff to order X-rays, routine tests, and treatment for myself. In the event of an emergency and neither my primary contact nor secondary can be reached, I hereby give permission to the physician selected by the Authorized Agent to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery to myself as named above.

I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release the church, its employees or agents from liability associated with participation in a church activity.

I understand that if I do not have medical insurance, I, as the parent or guardian, will be responsible for any medical expenses in the event of a sickness and/or injury.

I understand that there are risks involved in taking place in recreation activities and other activities related to participation in youth functions.

Signature of Parent/Guardian _____ Date _____

The following to be completed by the notary witnessing parent/guardian's signature.

The State of _____ the County of _____ Before me, a Notary Public, on this day personally appeared _____ known to me (or proved to me on the oath of _____) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this _____ day of _____, A.D. _____.

Notary Public, Signature _____

My commission expires the _____ day of _____, A.D. _____.