

MEDICAL & PHOTO/VIDEO PERMISSION RELEASE FORM

FIRST BAPTIST CHURCH, PELHAM, GA – PRESCHOOL, CHILDREN, & YOUTH MINISTRIES

Participant Information

Participant's Name: _____ Grade: _____ Date of birth: _____

Address: _____

Participant cell phone # _____ Participant email: _____

Father's Name: _____ Cell # _____ Home # _____ Work # _____

Mother's Name: _____ Cell # _____ Home # _____ Work # _____

Father's email: _____ Mother's email: _____

In Case of Emergency

(Please list family members or friends to contact should a parent be unavailable)

Name: _____ Relationship to participant: _____ Phone: _____

Name: _____ Relationship to participant: _____ Phone: _____

Medical Information

Known Allergies: _____

Current Medications: _____

Other Limitations / Restrictions: _____

PERMISSION FOR TREATMENT, PHOTO/VIDEO NOTICE, RELEASE AND INDEMNITY

My permission is granted for any staff person, worker/chaperone, or any adult present or in charge of First Aid, to obtain necessary medical attention in case of sickness or injury to my child.

Also, I understand that as a participant, my child may be photographed or videotaped during normal trip activities and these photos/videos may be used in videos and/or photo walls.

I, the undersigned, do hereby verify that the above information is correct and I do hereby release and forever discharge all sponsors, state convention and employees, and the First Baptist Church of Pelham, Georgia from any and all claims, demands, actions or cause of action, past, present, or future arising out of any damage or injury while attending Preschool, Children or Youth Department events both on church property and away from campus.

I agree to indemnify all sponsors, state conventions and employees, and the First Baptist Church of Pelham, Georgia from any and all claims, demands, actions or cause of action, past, present, or future arising out of any damage or injury while attending Preschool, Children or Youth Department events and/or while on the property where said events are held.

*****I understand that I will be held responsible for the cost of any medical care deemed necessary for my child.***

Parent Signature _____ Date: _____