2018 – 2019 Medical Release & Permission Form

Please print in ink

Name:____Age_______Birthday_____________

Last First Middle

Year in school:________________ Gender: M / F Email:____________________________________

Address:___________________________________ City:_______________ State:___ Zip:_________

Phone:______________________________ Cell:______________________________________

Medical Insurance Company:_____________________________ Policy #:________________________

Mother's Name:_______________________________ Phone:_______________ Work:______________

Father's Name:________________________________ Phone:_______________ Work:______________

Emergency Contact:____________________________ Phone:_______________ Work:______________

Physician:______________________________________ Office Phone:________________________

Dentist:____ Office Phone:________________________

MEDICAL HISTORY

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof.

Checking the following areas of concern for this student. If necessary, add another page with details:

1. Medications currently taking:____
   ____

2. Does your child have allergies to:
   ____pollens ____medications ____food ___insect bites
   ____

3. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:
   _____asthma ____epilepsy/seizure disorder ___heart trouble ____diabetes
   _____frequently upset stomach ___physical handicap
   ____

4. Date of last tetanus shot:____________________
5. Other information regarding my child's health that a doctor should know:_____________
   ____

For your information, we expect each student to conform to these rules of conduct:

No possession or use of alcohol, drugs, or tobacco
No fighting, weapons, fireworks, lighters, or explosives
No offensive or immodest clothing
Respect property
Respect one another, staff, and adult leaders
Respect and comply with event schedules

Students who fail to comply with these expectations may be sent home.

I, the student, have read and understand the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

Student signature:____ Date:____________

Activities may include, but are not limited to: climbing wall, afterschool program, cookouts, boating, water skiing, swimming, basketball, roller-skating, rollerblading, games in the park, soccer, broomball, ice skating, volleyball, softball, baseball, camping, downhill skiing, snowboarding, hiking, biking, concerts, Bible studies, golfing, miniature golf, hayrides. Permission is also granted for any transportation needs that may be necessary.

_____*I do not wish for my child to participate in the following activities:*___________________

____*Signature:*______________________

____ has my permission to attend all youth activities
Name of student
sponsored by Main Street Baptist Church (hereinafter the "Church") March 21st, 2018 to May 31st, 2019.

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.

I/We the undersigned have legal custody of the student names above, a minor, and have given our consent for him/her to attend events being organized by the Church. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/We hereby release the Church, its' pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/We consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician an d/or hospital personnel designated by the Church, I/We agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/We affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be force for the student named above.

Parent/guardian signature:____ Date:__________

Public Notary:____ Date:__________

Notary Expiration:__________________

Main Street Baptist Church (859-474-3100)