MEDICAL RELEASE FORM/PERMISSION TO TREAT

FIRST BAPTIST CHURCH, DYER, TN

PERSONAL INFORMATION
NAME:_____
BIRTHDATE:_____/_____/_____ AGE:_____ GENDER:_____
ADDRESS:_____ CITY:_____ STATE:_____
ZIP:_____

EMERGENCY CONTACT INFORMATION
PARENT/GUARDIAN:_____
HOME PHONE:(_____)_____ WORK PHONE:(_____)_____
SECONDARY CONTACT:_____
RELATIONSHIP:_____ MOBILE PHONE:(_____)_____
WORK PHONE:(_____)_____

INSURANCE INFORMATION
ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD TO THIS FORM.
INSURANCE CO.:_____ GROUP #:_____ POLICY #:_____ CARDHOLDER:_____
RELATIONSHIP TO CARDHOLDER:_____
INSURANCE CO.
ADDRESS:_____
INSURANCE CO. PHONE:(_____)_____

PERSONAL MEDICAL INFORMATION
PHYSICAL LIMITATIONS (ASTHMA, DIABETES, ALLERGIES, ETC.) AND/OR SPECIAL INSTRUCTIONS (ALLERGIC TO CERTAIN MEDS, RARE BLOOD TYPE, WEARS CONTACT LENSES, ETC.):_____
_____
_____
_____

LIST ANY MEDICATIONS TAKEN ON A REGULAR BASIS AND/OR ANY BROUGHT WITH YOU TO CAMP (PRESCRIPTION MEDICATIONS MUST HAVE A PHARMACY LABEL AND NAME OF DOCTOR): _____
_____
_____
_____

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.

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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 PART IN RECREATION ACTIVITIES AND OTHER ACTIVITIES RELATED TO PARTICIPATION IN YOUTH FUNCTIONS.

SIGNATURE OF PARENT/GUARDIAN:_____

DATE:_____