WADE BAPTIST CHURCH

2021-22 MEDICAL RELEASE FORM / PERMISSION TO TREAT

PARTICIPANT INFORMATION:

Name:_____ Phone # _____

DOB:_____/_____/_____ Age:_____ Grade:_____ Gender:_____

Address:_____ City:_____ State:_____ Zip: _____

EMERGENCY CONTACT INFORMATION:

Mother/Guardian: _____ Cell #: _____ Alternate #:_____

Father/Guardian: _____ Cell #: _____ Alternate #:_____

Preferred Parent Email Address: _____

Alternate Contact:_____ Cell #: _____ Alternate #:_____

INSURANCE INFORMATION: Attach a copy of your insurance card to this form.

Insurance Co.:_____ Group #:_____ Policy #:_____

Cardholder:_____ Relationship to Cardholder: _____

Insurance Co. Address:_____ Insurance Co. Phone: _____

PARTICIPANT MEDICAL INFORMATION (If none, so state.):

Physician's Name:_____ Phone: _____

Physical Limitations: (Asthma, diabetes, allergies, etc.)_____

Special Instructions: _____

Allergies: (Medications, foods, animals, latex, etc.) _____

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

_____

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

_____ (Initial) This Medical Release Form/Permission to Treat is true and correct, to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities, except as noted.

_____ (Initial) I hereby agree that if any changes occur in relation to my medical/health information, it is my responsibility to inform Wade Baptist Church by completing a new Medical Release Form/Permission to Treat.

EMERGENCY AUTHORIZATION: I hereby give permission to medical personnel selected by the Participant's Church sponsor, designee or camp staffer to initiate necessary treatment. In the event of an emergency, when neither my primary nor alternate contact can be reached, I, the undersigned, hereby give permission to the physician selected by the Authorized Agent to render proper treatment, including medications, injections, and imaging studies, as well as any necessary surgery/anesthesia.

I further authorize release of the above medical information to appropriate medical personnel and/or health insurers. I release Wade Baptist Church, its employees and 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 with recreation and other activities related to participation in church functions.

I understand that this form will be valid from the notarized date through August 31, 2022.

MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC.

Signature _____ Date_____

(Parent/Guardian must sign if child is under 18 years of age.)

STATE OF MISSISSIPPI COUNTY OF JACKSON

Personally appeared before me, the undersigned authority in and for the said county and state, on this _____ day of _____, 20_____, within my jurisdiction, the within named who acknowledged that the matters contained in the above letter are true and correct.

_____

NOTARY PUBLIC

My commission expires:_____