

MEDICAL/PERMISSION AND RELEASE FORM

NAME _____ S.S.# _____ AGE _____ DOB _____

ADDRESS _____ ZIP _____

IN CASE OF EMERGENCY NOTIFY: _____

PHONE: DAYTIME _____ EVENING _____

FAMILY PHYSICIAN _____ PHONE _____

FAMILY INSURANCE CO. _____ POLICY # _____

MEDICAL HISTORY

CHILDHOOD DISEASES: ___ Chickenpox ___ Measles Mumps ___ Whooping Cough ___ Other _____

DATES OF IMMUNIZATIONS: ___ Tetanus ___ Polio Booster ___ Measles ___ Mumps
___ Hepatitis A ___ Hepatitis B ___ Other _____**MEDICAL CONDITIONS:**___ Asthma ___ Sinusitis ___ Bronchitis ___ Kidney Trouble ___ Heart Trouble ___ Diabetes
___ Dizziness ___ Stomach upset ___ Hay Fever ___ Seizures ___ Other _____**ALLERGIES: (List type)**_____
_____**CURRENT MEDICATIONS:**

List Name and Dosage _____

Special Diet: (Detail any special needs) _____

PERMISSION FOR TREATMENT

The person described on this registration form has my permission to attend **all events** and to participate in **all activities** for the following school year date of _____. I also give permission for the person described on this registration form to ride in both personal and church vehicles operated by the staff or adult leaders of First Baptist Church of Battlefield. If a medical emergency should arise while my child or ward is at the event or in transit to the event and I cannot be reached, I consent and give my permission to the staff or an adult leader of First Baptist Church of Battlefield to select a physician and/or hospital for my child's or ward's care. I also give the physician and/or hospital, as selected by the staff or an adult leader of First Baptist Church of Battlefield, my permission to hospitalize, treat, give x-rays, tests, and to order injections, anesthesia, or surgery for my child or ward who is named herein, which may be in their sole discretion by necessary and proper under the circumstances. I do release, acquit, discharge, and agree to hold harmless First Baptist Church of Battlefield, Missouri, its staff and representatives, of any and all actions, damages, or liabilities arising out of the treatment of any sickness or accident incurred by my said child or ward, or the disclosing any information, if requested. I further understand that in the event of a medical emergency requiring medical care, as I have authorized below, all costs for such emergency care ARE MY RESPONSIBILITY and I agree to make payment of all such medical costs.

Dated this _____ day of _____, 20 ____.

Signature of Parent/Guardian
(Youth 18 years or older may sign)