

MEDICAL RELEASE/CONSENT FORM

First Baptist Church

1597 Sawnee Dr., Cumming, GA 30040

770-887-2428

Church Activity

Date -- From: _____ **To:** _____

Name: _____ Grade: _____th Date of Birth: _____

Address: _____ Zip: _____

Email: _____ Gender: _____

Parent's Name: _____

Home Phone: _____ Father's Work Phone: _____

Cell Phone: _____ Mother's Work Phone: _____

Emergency contact other than parent: _____

Relationship _____ Phone: _____

Doctor's Name: _____ Phone: _____

Insurance Company: _____ Phone: _____

Policy Number: _____ Insured: _____

I hereby consent to the participation in the above referenced activity conducted under the sponsorship of First Baptist Church, Forsyth County, Georgia. In making such consent, participant and parent acknowledge that they understand there are risks to both person and property associated with engaging in such activity, and they thereby consent to assume such risk.

In consideration of granting permission for the participation in such activity, participant and parent hereby release and hold harmless First Baptist Church, its employees, agents and members from any and all liability pertaining to such activity. Participant and parent expressly covenant not to sue and do hereby waive and relinquish whatever right either may have against First Baptist Church, its employees, agents or members by virtue of the sponsorship of such activity.

As parent, I hereby authorize and consent to any emergency medical treatment, including but not limited to X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to my child on the advice of a licensed physician, surgeon, anesthesiologist, dentist or other qualified medical personal acting under their supervision. I fully assume responsibility for any and all medical expenses which may be incurred.

Should it be necessary for my child to return home due to medical reasons or disciplinary action, I hereby assume all transportation costs.

Medication being taken: _____ Dosage _____
_____ Dosage _____

List any known allergies/physical problems: _____
_____ Date of last Tetanus shot: _____

May he/she be administered (initial all that apply)

Tylenol Benadryl Pepto Bismol First Aid Cream/Spray Neosporin

Participant's Signature: _____

Parent/Guardian's Signature: _____ Dated _____

Witness _____ Dated _____