first baptist duluth **EMERGENCY MEDICAL RELEASE FORM-Youth & Children's Ministry**

First Baptist Church, 2908 Highway 120, Duluth, Georgia 30096 770.476.3788

This form is effective from the date of signature through August 31, 2017.

Youth/Child's Name _____

Date of Birth: _____/_____/_____ Current Grade: _____

Address _____

Name(s) of Parent(s)/Legal Guardians(s) _____

Home phone _____ Business phone _____

Cell phone _____ Other phone _____

ALTERNATE person to contact in case of emergency if parent cannot be reached-

Name _____ Relationship _____

Phone _____ Cell phone _____

INSURANCE INFORMATION and MEDICAL HISTORY (attach a copy of the front and back sides of your ins. card)

Insurance Company _____ Phone Number _____

Policy Number _____ Group Number _____

Known allergies to food, drugs, bee stings, etc.

_____

_____

List all medications currently taken and what condition it is taken for.

_____

_____

Date of last Tetanus ___/___/___

Family Physician _____ Phone Number _____

MEDICAL RELEASE: I give the adult sponsors of First Baptist Church of Duluth the authority to provide or sign for medical treatment for above said child.

RELEASE OF LIABILITY: That I, the undersigned, being the parent or legal guardian of above said child who is a member of the group traveling with First Baptist Church of Duluth, do hereby constitute and appoint any adult chaperone traveling with the said group as my true and lawful attorney-in-fact for the limited purpose of consenting to any reasonable necessary medical attention which might be needed by my child as a result of injuries or sickness occurring while said child is engaged in any activity connected with the First Baptist Church of Duluth.

- Also, I do not hold First Baptist Church of Duluth, its Ministers, or volunteer assistants, any resident organization and/or camp facility, its staff, employees, or board liable for any injuries, accidents, or illnesses incurred during scheduled retreat/camp dates and times for which my child will be on their property.
- I further authorize my said attorney-in-fact to execute any and all documents, consent forms, or any other instruments which might be necessary to authorize a physician or hospital to perform any such reasonably necessary medical services to my child and do hereby ratify and confirm the act of my said attorney-in-fact in doing so. I understand that any personal medical and hospitalization insurance available to my family will provide primary coverage.

Notary Seal

Signature:_____

Date:_____

_____

Signature of Parent(s)/Legal Guardians

_____

Date