

Student Medical Release Form

STUDENT'S INFO: Full Name: _____ Goes by: _____
Birth date: ___/___/___ Age: ___ Gender: ___ School: _____ Current (or just completed) Grade: ___
Address: _____ City: _____ State: ___ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____

PARENT/GUARDIAN INFO: Mother's Name: _____ Mother's Cell: (____) _____
Father's Name: _____ Father's cell: (____) _____ Home Phone: (____) _____

SECONDARY CONTACT: (To notify in case of emergency and you can't be reached.) Name: _____
Their relationship to student: _____ Cell phone: (____) _____ Home phone: (____) _____

INSURANCE INFO: (Please attach a copy of the front & back of your insurance card.)
Medical Insurance Co.: _____ Group# : _____ Policy#: _____
Company's address: _____ Company's Phone: (____) _____
City: _____ State: _____ Zip: _____ Preferred Network Hospital: _____

STUDENT'S MEDICAL INFO:

- Physical Limitations (Asthma, diabetes, allergies, etc.), and/or special instructions: (Allergic to certain meds, rare blood type, wears contact lenses, etc.) _____
- List ALL medication taken on a regular basis (Prescription meds MUST have a pharmacy label and name of doctor): _____
- List all operations/serious injuries and dates within the past five (5) years: _____
- Date of last Tetanus Shot: _____

Doctor's Name: _____ Address: _____ Phone: (____) _____
Dentist's Name: _____ Address: _____ Phone: (____) _____

EMERGENCY AUTHORIZATION:

I hereby verify that the Health History above is correct, as far as I know, and the person herein described above has permission to engage in all prescribed activities except as noted. I hereby give permission to medical/dental personnel selected by the First Baptist Church sponsors to order X-rays, routine tests, and treatment for my child. In the event of an emergency and neither the secondary contact nor myself can be reached, I hereby give permission to the emergency personnel, physician, or dentist selected by the First Baptist Church sponsors to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery for my child as named above. I further authorize the release of the above medical information to appropriate medical/dental personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release First Baptist Church, its staff, or sponsors from liability associated with participation in First Baptist Church Student Ministry activities and events. This Medical Release shall remain in effect from January 1, 2020 until December 31, 2020

Signature of Parent/Guardian: _____ **Date:** _____