First Baptist Church
2020 *Medical Release Form*

First Baptist Church
219 Cleland St.
Georgetown, SC 29440
Phone (843) 546-5187

To be filled out by Parent or Guardian only: We, the undersigned parent(s) or legal guardian(s) for _____, do release, forever discharge and agree to hold harmless First Baptist Church (Georgetown) and its representatives thereof from any and all liability, claims, or demands for personal injury, sickness, or death, as well as property damage and expenses of any nature whatsoever which may be incurred by my child in the course of participation in First Baptist Church activities in the year of 2020.

We give authorization for First Baptist Church to provide all necessary food, transportation, and lodging.

We give our permission for our child to participate in First Baptist student activities and for any adult representative of the church to obtain necessary medical treatment. We, the parents or guardians, assume responsibility for any medical bills incurred.

Should our child have to return home before the group for medical or disciplinary reasons, we hereby assume any costs incurred.

_____
Parent or Guardian

This agreement authorizes any licensed hospital or professional to render medical/surgical care as deemed necessary for the emergency

_____
Parent or Guardian

_____ _____
Notary Date
My Commission Expires:

General Information (*Please Print*)

Name:_____ Male:_____ Female:_____

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address:_____

City: _____ State: _____ Zip: _____

Phone:_____ Birth Date: _____ Age: _____ Grade: _____ School: _____

Student Cell Phone: _____ Parent Cell Phone: Father _____ Mother _____

Beeper Number: _____ Fax Number: Father _____ Mother _____

Email Address: Student _____ Parent _____

Health Information

Father's Name: _____ Occupation: _____ Work Number: _____

Mother's Name: _____ Occupation _____ Work Number: _____

In an emergency, please notify (other than yourself):

_____ Relationship: _____ Phone Number: _____

_____ Relationship: _____ Phone Number: _____

Family Doctor: _____ Name of Practice: _____ Phone Number: _____

Address: _____

Insurance Carrier: _____ Policy Number: _____

Are there any physical or medical conditions or restrictions? Yes _____ No _____

If yes, please explain and indicate nature and extent:

_____

Any known allergies or allergic reactions? _____

Last tetanus shot: _____ May aspirin be given? Yes: _____ No: _____

May your child be given acetaminophen (such as Tylenol)? Yes: _____ No: _____ Others _____

May your child be given a stomach ache remedy such as Pepto Bismol? Yes: _____ No:_____

Any other condition that would be helpful in treating your child ? _____

Parent or Guardian Signature: _____ Date: Month Day