

Medical Release Form for First Baptist Events

Valid for Youth Events June 1, 2010 to August 31, 2011

(Must be completed by parent or guardian)

PLEASE PRINT LEGIBLY!

Student Name: _____
Last First Middle Initial

Birth date: ____ / ____ / ____ Current Age: _____ Gender: Male Female

Home address: _____
Street Address City State Zip Code

Parent/Guardian: _____ Home Phone: (____) _____

Parent Cell Phone: (____) _____ Work Phone: (____) _____

Student Cell Phone: (____) _____ Student Email: _____

***** Date of last tetanus immunization: ____ / ____ / ____ *****

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Is the Youth covered by family medical/hospital insurance? Yes No

If yes, indicate carrier or plan name: _____

Name of insured: _____ Relationship to Youth: _____

Social security number of policyholder or insurance ID number: _____

Hospital preference if Youth Event is in Wichita, KS: _____

Please list all known allergies:

Please list Medications & Dosages currently being taken:

Check here to grant permission for the Youth Sponsor to administer over-the-counter medications for pain, fever or upset stomach relief: YES NO

List any medication restrictions (for over-the-counter medications) as to dosage: _____

Important—this box must be completed

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all Youth activities except as noted on an attached page. I give permission to the medical personnel selected by the Youth Sponsor(s) to order x-rays, routine tests, and treatments; to release any records necessary for insurance purposes; and to provide or arrange as necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Youth Sponsor to secure and administer treatment, including hospitalization, for the person named above. I further grant permission to the Youth sponsor to administer the medication(s) listed on back page in accordance with the prescribed dosage(s).

Signature of parent/guardian: _____

Printed name: _____ Date: ____ / ____ / ____