Medical Release Form / Permission to Treat

First Baptist Church
510 W Main St.
Knoxville, TN 37902
(865) 546-9661

Personal Information:

Name: _____ T-Shirt Size:_____

SS # (optional): _____ DOB: _____/_____/_____ Age:_____ Gender:_____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information:

Parent/Guardian: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Secondary Contact: _____ Relationship: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Insurance Information:

*Attach a copy of your insurance card to this form.

Insurance Co.: _____ Group #: _____ Policy #: _____

Cardholder: _____ Relationship to Cardholder: _____

Insurance Co. Address: _____

Insurance Co. Phone: (_____)_____

Personal Medical Information:

Physician's Name: _____ Phone: (_____)_____

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:

_____

_____

List all operations/serious injuries and dates within the past five (5) years:

_____

_____

The Health History is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted.

Emergency Authorization - I hereby give permission to medical personnel selected by the First Baptist Church Knoxville staff to order X-rays, routine tests, and treatment for myself. In the event of an emergency and neither my primary contact nor secondary can be reached, I hereby give permission to the physician selected by the Authorized Agent to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery to myself as named above.

I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release the church, its employees or agents from liability associated with participation in a church activity.

I understand that if I do not have medical insurance, I, as the parent or guardian, will be responsible for any medical expenses in the event of a sickness and/or injury.

I understand that there are risks involved in taking place in recreation activities and other activities related to participation in youth functions.

I grant my permission to the foregoing parties to use any photographs, motion pictures, recordings, or any other record of participation in youth functions for any legitimate purpose.

Signature of Parent/Guardian _____ Date _____

The following should be completed by the notary witnessing parent/guardian's signature.

The State of _____ the County of_____

Before me, a Notary Public, on this day personally appeared _____ known to me (or proved to me on the oath of_____) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this _____ day of_____, A.D._____.

Notary Public, Signature _____

My commission expires the _____ day of_____, A.D._____.

(White Form)