

# Medical/Release Form

First Baptist Church  
PO Box 635  
Greenwood, AR 72936  
479-996-2166

**Both sides of this form must be completed.**

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Emergency Contact other than Parent/Guardian \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

The undersigned as parent or guardian of the person listed above, hereby authorizes any staff members and/or adult sponsor who may be supervising or directing any activity sponsored by the First Baptist Church, Greenwood, Arkansas, to authorize emergency medical treatment for the person listed above while this person is participating in any trip, excursion, or activity sponsored by the First Baptist Church of Greenwood, Arkansas.

Furthermore, I release the First Baptist Church, its staff, employees, and sponsors from any liability for personal injury, damage or loss that the above named person may sustain even if such personal injury or other loss is caused by the ordinary negligence of the First Baptist Church, its employees, staff members or designated sponsors.

I agree to allow the staff and sponsors selected by the First Baptist Church to discipline my child during any activities if, in the sole judgment of such staff sponsor or other designated sponsor, such discipline is necessary. I have explained to my child the attitude and actions expected during such activities. If any staff sponsor or other designated sponsor deems it necessary for my child to return from any trip due to illness, injury, or misconduct, I agree to be responsible for all costs associated with such a return trip.

Parent/Guardian Name \_\_\_\_\_

Parents/Guardian Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

# Insurance Information

This information will be requested by the physician and medical facility in the event of an emergency. Please help us by making sure you give complete and correct information. This Medical/Release Form will be kept on file at the church office. If any of the information you have provided should change, please complete a new form and return it to the church office.

Parent/Guardian Name \_\_\_\_\_

Social Security Number of Insurance Policy Holder \_\_\_\_\_

Policy Carried under what name \_\_\_\_\_

Parent/Guardian Occupation \_\_\_\_\_

Company Name \_\_\_\_\_

Company Address(city, state, zip) \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Insurance Company Address(city, state, zip) \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Please explain any medical problems \_\_\_\_\_

Please list any medication and why it is taken:

\_\_\_\_\_  
\_\_\_\_\_

Please list any medication that would cause allergic reaction:

\_\_\_\_\_  
\_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_