



Medical Release Form / Permission to Treat

Name of Church: Greenwood Baptist Church City/State: Gray, GA

Name: _____

Address: _____

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

City: _____ State: _____ Zip: _____

Emergency Contact Information:

Parent/Guardian: _____

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

Secondary Contact: _____ Relationship: _____

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

Insurance Information:

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.):

(Continue on back.)

List ALL medication taken on a regular basis and/or any brought with you to Camp. (Prescription meds MUST have a pharmacy label and name of doctor.)

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 participant's Church sponsor/his designee or camp 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.

Signature of Parent/Guardian _____ Date _____