



Date: \_\_\_\_\_

### MEDICAL RELEASE FORM

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

#### FOR STUDENTS:

Father's name: \_\_\_\_\_ Cell: \_\_\_\_\_

Place of employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's name: \_\_\_\_\_ Cell: \_\_\_\_\_

Place of employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Legal guardian of student: father \_\_\_\_\_ mother \_\_\_\_\_ both \_\_\_\_\_ other \_\_\_\_\_

If other, please give name and address: \_\_\_\_\_

Father's Social Security #: \_\_\_\_\_ Mother's Social Security #: \_\_\_\_\_

If an emergency occurs, and parents/guardian can't be reached, please call:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Social Security #: \_\_\_\_\_ Mother's Social Security #: \_\_\_\_\_

I give my permission to any authorized personnel of First Baptist Church Russellville to take emergency measures deemed necessary for the care and protection of my student while under their supervision. In case of accident or illness, I understand that my student will be taken to an appropriate medical facility for treatment. It is understood that in severe situations, the adults in charge may contact the local emergency resource before the parent, student's physician, and other adults acting on the parent's behalf.

I understand that any expense incurred will be the responsibility of the student's family.

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any:

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Hospital with records: \_\_\_\_\_

Health problems: \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Policy # or group number: \_\_\_\_\_

I give my permission to any authorized personnel of First Baptist Church Russellville to take emergency measures deemed necessary for my care and protection while under their supervision. In case of accident or illness, I understand that I will be taken to an appropriate medical facility for treatment. It is understood that in severe situations, the adults in charge may contact the local emergency resource before my family or personal physician. **I understand that any expense incurred will be my responsibility.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE: THIS RELEASE WILL REMAIN IN EFFECT UNTIL JANUARY, 2009.**