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# MEDICAL RELEASE FORM

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ City, Church Name \_\_\_\_\_

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

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ (If different from above)

Employed by \_\_\_\_\_

Daytime Phone (\_\_\_\_) \_\_\_\_\_ Evening/Night Phone (\_\_\_\_) \_\_\_\_\_

Are you currently taking medicine or treatment?  yes  no

If yes, explain \_\_\_\_\_

Have you been restricted from sports or swimming for any reason?  yes  no

If yes, explain \_\_\_\_\_

Date of last Tetanus Toxoid Immunization: Month \_\_\_\_\_ Year \_\_\_\_\_

Have you ever had a severe reaction to a bee/hornet sting, or insect bite?  yes  no

If yes, explain \_\_\_\_\_

**Do you have:**

Sinus Trouble

Hay Fever

Heart Trouble

Epilepsy

Asthma

Diabetes

Communicable diseases? If yes, please explain \_\_\_\_\_

**List any Allergies:**

Food \_\_\_\_\_

Drugs \_\_\_\_\_

Other Medical Needs: \_\_\_\_\_

NOTARY SPACE

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## EMERGENCY MEDICAL AUTHORIZATION

Event: \_\_\_\_\_

In the event of an emergency, I hereby give permission to the appointed sponsor who is with my child or to any Kansas-Nebraska Convention of Southern Baptists staff person, or their designee, who is present at the above mentioned event to obtain medical assistance for my child. I also give permission to the Physician selected to hospitalize and secure proper treatment for my child.



Parent/Guardian Signature \_\_\_\_\_

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

Mailing Address to Submit Claims: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

If I cannot be reached, please notify \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ or (\_\_\_\_) \_\_\_\_\_

Today's Date \_\_\_\_\_

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