OAK GROVE
BAPTIST CHURCH

Medical Release Form / Permission to Treat

January 1, 2017 – December 31, 2017

Name of Church: Oak Grove Baptist Church **City / State:** Bel Air, MD 21015

Today's Date: _____

Personal Information:

Name: _____

DOB: ____/____/____ Age: _____ Grade: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information:

Parent / Guardian: _____ Cell: (____)_____

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

Secondary Contact: _____ Relationship: _____

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

Child's Insurance Information:

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

Cardholder: _____ Relationship to Cardholder: _____

Photo Release:

I understand by my child participating in a church event, photos and/or video may be taken. These photos may be used through print and web for advertising or decorative purposes.

Parent / Guardian Signature:_____

Child's Personal Medical Information:

Physician's Name:_____Phone: (____)_____

Physical Limitations (Asthma, diabetes, allergies, etc.) and / or Special Instructions (Allergic to certain meds, animals, rare blood type, wears contact lenses, etc.):

_____

List ALL medication taken on a regular basis and / or any brought 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 – My permission is granted to OAK GROVE BAPTIST CHURCH through its staff, personnel, representative of camp, employee, or agent to provide all necessary medical attention in case of sickness or injury to my child. I hereby give permission to medical personnel selected by my child's Church sponsor / his designee or camp staff to order X-rays, routine tests, and treatment for my child. 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 student functions.

Signature of Parent / Guardian _____ Date _____

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

State of _____

County of_____

Personally appeared before me, _____, with whom I am personally acquainted, and who acknowledged that he/she executed the within instrument for the purposes therein contained.

Witness my hand this _____ day of _____, 20____.

Notary Signature:_____

My commission expires: _____