Medical Release Form

Name _____ Sex ____ Grade ____ Age_____
Date of Birth _____ Social Security # _____
Address _____
Parents or Guardians Name _____
Home Phone ( ) _____ Work Phone ( ) _____

Medical Insurance _____ Policy # _____
(Insurance Company)
Phone # of Insurance Co. ( ) _____

Does this student have any of the following allergies:

Penicillin	[ ] Yes	[ ] No	Other _____
Other Drugs	[ ] Yes	[ ] No	_____
Insect Stings	[ ] Yes	[ ] No	_____
Ivy Poisoning	[ ] Yes	[ ] No	_____
Hay Fever	[ ] Yes	[ ] No	_____

Does this student have any medical or health problems, and has this student had any chronic or recurring illness or illnesses which would have an effect on the students participation in church activities? [ ] Yes [ ] No
If yes, describe the problem or illnesses.

Is this student on any medication? [ ] Yes [ ] No
If so, please state the medication: _____

Describe any dietary restrictions that this student is required to observe.

Person to contact in case of an emergency (if we are unable to reach parent)

_____ _____
(Name) (Phone #)

Authorization For Emergency Medical Care to Minors
The undersigned parent or legal guardian of the above named minor, hereby authorizes FIRST BAPTIST CHURCH, Durham, or its agents (the temporary custodians of the minor) to consent to or permit any duly licensed physician or dentist to prescribe any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the above minor under the general or special supervision or advice of any or several physician(s), surgeon(s), or dentist(s) licensed under the laws of any state, whether such diagnosis or treatment is rendered at the office of the physician, surgeon, or dentist, or at a hospital licensed by any State.

Signature of Parent or Guardian _____ Date _____

Relationship to Minor _____