

FBC PLAQUEMINE MEDICAL RELEASE FORM

To Whom It May Concern:

The undersigned does hereby give permission for our (my) child, _____, to attend and participate in the activities and camps sponsored by First Baptist Church Plaquemine during the year 2008.

We (I) authorize an adult in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medial staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the above mentioned child pursuant to the authorization.

I further authorize the release of the above medical information to appropriated medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release First Baptist Church Plaquemine, its employees, or any adult in whose care the minor has been entrusted, from liability associated with participation in any activity.

The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by First Baptist Church Plaquemine.

The undersigned also gives permission for adult sponsors with due cause to search any belongings suspected of containing anything that may cause harm to the child or others on the trip. I understand that this will be done only in the presence of a witness.

The undersigned also gives permission for our (my) child to appear in any publicity, advertisement, or media distributed to the public related to First Baptist Church Plaquemine.

Student's Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (____) _____

Age _____ Birth Date ___/___/___ Social Security Number ____-____-_____

School _____ Grade _____

In case of emergency notify (other than parents) _____

Relationship _____ Phone Number (____) _____

Physician _____ Phone Number (____) _____

Insurance Company _____

Policy Number _____

WE MUST HAVE A COPY OF YOUR INSURANCE CARD.

OVER

PARENT'S INFORMATION:

Father's Name: _____

Home Phone () _____ Business Phone () _____ Cell () _____

Date of Birth _____ Social Security Number ____ - ____ - _____

Mother's Name: _____

Home Phone () _____ Business Phone () _____ Cell () _____

Date of Birth _____ Social Security Number ____ - ____ - _____

MEDICAL HISTORY:

Immunizations: _____ Tetanus ____/____/____ Date of Last Tetanus

_____ Polio Booster _____ Measles/Mumps

Other: _____

CHECK BELOW TO GIVE APPROPRIATE INFORMATION:

_____ Asthma _____ Sinusitis _____ Bronchitis _____ Kidney Trouble

_____ Diabetes _____ Dizziness _____ Hay Fever _____ Heart Trouble

_____ Stomach Upset _____ Other

List Other: _____

ALLERGIES:

Food: _____

Penicillin or other drug (name): _____

Insect sting/bite _____ Poison Sumac, oak, ivy _____

Pervious operations or serious illness (ALL within past five years): _____

Do you have any special health information that we should be aware of? _____

SIGNED (Mother, Father, or Legal Guardian) in the presence of a Notary

_____ Date: _____

Print Full Name: _____

Sworn and signed this the _____ day of _____ 20 _____.

Notary _____

My commission expires _____.