

STUDENT INFORMATION

Dear Parent or Guardian:

For the year _____ (fill in yr.)

This Medical Release form must be completed and signed in order for your child to participate.
ONE FORM MUST BE COMPLETED FOR EACH CHILD. **PLEASE PRINT.**

Student's Name _____ Age _____ DOB _____ Grade _____

Address _____ City _____

State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

Parent/Guardian

I, the undersigned parent/guardian of _____ do hereby authorize the adult sponsor of **First Baptist Church of Mira Mesa** Student programs bearing this written authorization, into whose said care the above minor child has been entrusted, to obtain proper medical care from a licensed medical or dental doctor or facility, in the case of an emergency. The medical/dental care is to include, but is not limited to, any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which the aforementioned physician or dentist in the exercise of his best judgment may deem advisable. This authorization shall include transportation and receive medical or dental care.

FINANCIAL RESPONSIBILITY

In the event of injury or illness to my child/ward, I agree that I/we and my health care insurer shall be financially responsible for any medical treatment required by my child/ward as a result of any injury or illness suffered during his/her participation in any church related activities.

RISK

(Athletics, games, travel, hiking, climbing, projects, hobbies, and other related activities.) I am aware that these activities may involve some hazard. I have considered these risks and I still wish my child to participate. In consideration of my child/ward participating in these activities, I agree not to bring legal action against **First Baptist of Mira Mesa** staff or sponsor as a result of any injury or illness suffered in the course of my child/ward's participation.

I have read and understand the terms of this agreement.

Parent/Legal Guardian's Signature _____ Date _____

MEDICAL INFORMATION

In case of an emergency please contact

Home phone _____ Work phone _____ Cell phone _____

Any other contact numbers _____

Medical Insurance Company _____ Policy # _____

Doctor's Name _____ Phone # _____

Last Tetanus Shot: _____

Are there any physical or medical conditions or restrictions?

If so, please explain

Any known Allergies?

___ Drug Allergies ___ Asthma ___ Hay Fever ___ Insect Stings

___ Diabetes ___ Cardiac ___ Chronic Asthma ___ Epilepsy

___ Nervous Disorder ___ Physical Disorder ___ Emotional Disorder ___ Seizures

If you have checked any of the above, please give details

PERMISSION TO ADMINISTER MEDICATIONS (OR ITS EQUIVALENT) – Please check all that apply

Tylenol ___ Ibuprofen ___ Aspirin ___ Pepto Bismol ___ Neosporin ___ Sudafed ___

Is there anything else pertaining to the health of the child/ward that we need to know? Please explain:
