Medical Release Form / Permission to Treat

Zion Hill Baptist Church, Wesson, MS

January 1, 20____ thru December 31, 20____

Personal Information:

Name: ____

SS # (optional): ___________________________ DOB: ______ /______ / ________ Age: __________ Gender: __________

Address: ____

City:____ State: ____________ Zip: _______________________

Emergency Contact Information:

Parent/Guardian: ____

Home Phone: _________________________________ Work Phone: ____

Secondary Contact: ____ Relationship: ____________________________

Home Phone: _________________________________ Work Phone: ____

Insurance Information:

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

Insurance Co.:____________________________ Group#:______________________ Policy#: _______________________

Cardholder:_____________________________________ Relationship to Cardholder:_____________________________

Insurance Co. Address: ____

Insurance Co. Phone: ______________________________

Personal Medical Information:

Physician s Name: ____ Phone: ______________________________

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

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List ALL medication taken on a regular basis and/or any brought with you to Camp. (Prescription meds MUST have a pharmacy label and name of doctor.):

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List all operations/serious injuries and dates within the past five (5) years:

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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

I hereby give permission to medical personnel selected by the participant s Church sponsor/his designee or camp staff to order X-rays, routine tests, and treatment for myself. 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 the 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 all church activities for the year. 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 youth functions.

Signature of Parent/Guardian ______________________________________ Date: _______________

NOTARY ACKNOWLEDGEMENT

The State of ______________________

County of ________________________

Personally appeared before me, the undersigned authority in and for said county and state, on this _______________ day of ___________________________ , _______________, within my jurisdiction, the within named ____, who acknowledged that (he/she) executed the above and foregoing instrument.

____(SEAL)

Notary Public

Printed Name: __________________________________

My Commission Expires: ____________________________