FIRST BAPTIST CHURCH

FINDING HOPE AND LIFE IN JESUS

P.O. Box 324, Waldoboro, Maine 04572 ~ Phone: (207) 832-7659

# EMERGENCY INFORMATION AND MEDICAL RELEASE FORM

September 2018 – August 2019

Child's Name: ______________________________________ Date of Birth: ____/____/_______
Address: _______________________________________________________________________
City: ____________________________________________ Zip: ________________________
Home Phone: (        ) ________ - ____________

Father / Guardian: _______________________________________ Cell #: (____)_____-______
Employer: ____________________________________________ Work #: (____)_____-______
Mother / Guardian: ______________________________________ Cell #: (____)_____-______
Employer: ____________________________________________ Work #: (____)_____-______

*Allergies:* _________________________________________________________________________
*Medications:* ______________________________________________________________________

**OTHER PERSONS TO NOTIFY IN CASE OF EMERGENCY**:

Name: ___________________________________________ Relation: ____________________
Address: ________________________________________ Phone: (____)______-_________
Name: ___________________________________________ Relation: ____________________
Address: ________________________________________ Phone: (____)______-_________

**CONSENT & MEDICAL RELEASE FOR CHURCH ACTIVITIES:**

I understand that during September 2018- August 2019, my child will participate in various activities, both at the church and away from the church campus. I understand that transportation for these outings is provided by First Baptist Church leaders and volunteers. I give permission for my child to participate in these activities. In the case of an emergency, I authorize said adult leader (person must be 21 years of age) to act as my agent and to follow the procedure as listed below:

*Time & situation permitting to make reasonable attempts to contact myself or our named agents. When I or my agents cannot be contacted, the adult leader is to act in our behalf. Time & situation permitting, to contact the following medical doctor and / or to seek appropriate medical care.*

Dentist: _________________________________________ Phone: (____)______-_________
Doctor: _________________________________________ Phone: (____)______-_________
Insurance Carrier: ________________________________ Phone: (____)______-_________
Policy Number: __________________________________ Group Number: _______________

I authorize the adult leader to consent for any x-ray, examination, anesthetic, medical or surgical treatment, and hospital care which is recommended by any licensed physician or surgeon for my child. I understand that incomplete information above could delay my child from receiving needed medical attention. ______ (initial)

**Signature of Parent(s) or Guardian(s):** ________________________________ Date: ___________

________________________________ Date: ___________