MEDICAL RELEASE FORM 2021
FIRST BAPTIST CHURCH, RICHMOND, KY

(PLEASE PRINT)

Name of Student _____________________________________ Date of Birth _________________

Address ____ Age ______________

City ___________________________________ State ______ Zip _______________

Phone Number (_____)___________________ Sex _______ Height _______ Weight _______

Emergency Contact Person:

Parent/Guardian Name ____

Address (if different from student) ____

City ___________________________________ State ______ Zip _______________

Phone Numbers: (H) (_____)_____________ (W) (_____)______________ (C) (____)______________

Alternate Contact Person: (Use someone other than Parent/Guardian):

Name ____

Address (if different from student) ____

City ___________________________________ State ______ Zip _______________

Phone Numbers: (H) (_____)_____________ (W) (_____)______________ (C) (____)______________

If you have medical insurance, you or your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity. **If you do not have insurance you will be billed.**

Do you have health insurance? ______Yes ______No

Name of Insurance Co. ___________________________________ Phone Number (____)__________

Policy Number ___________________________ Group Number ______________

In whose name is the insurance? ____

Family Physician____ City _________________________

Physician Phone Number (_____)_________________

(Please turn over and complete the Health History.)

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If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him/her proper medical care during his/her time with the youth ministry activity. If they are currently on medication we ask that they NOT stop taking that medication while on a youth ministry activity.

Health History:

Pre-existing or present medical conditions ____

____

Name and dosage of any medications that must be taken ____________________________________

____

Any allergies? ___________________________ To medications? _________________________________

____ Hay Fever ____ Heart Condition ____ Diabetes ____ Insect Stings

____ Epilepsy/Nervous Disorders ____ Asthma ____ Frequent Stomach Upsets

____ Physical Handicap ____ Other ____

____ Any major illnesses during the past year?

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions)

____

____

Date of Last Tetanus Shot ___________________ Contact Lenses? ____________________

Any activity restrictions? ______ Yes ______ No

What? ____

Please use the remaining page to give any other pertinent information to us.