220 MEDICAL RELEASE FORM

Galatians 2:20 I have been crucified with Christ and I no longer live, but Christ lives in me. The life I now live in the body, I live by faith in the Son of God, who loved me and gave himself for me.

Name of Church:_____ City/State:_____

Name:_____ Social Security #:_____

Birthdate:____/____/_____ Age:____ Sex (M/F):_____

Address:_____

City:_____ State:_____ Zip:_____

Parent/Guardian:_____

Home Phone:(___)_____Work Phone:(___)_____

Secondary contact to notify in event of emergency:_____

Their relationship to you:_____ Their phone:(___)_____

Please supply ALL of the following information. Attach a copy of your insurance card.

Medical Insurance Co.:_____ Group#_____ Policy#:_____

Company's address:_____ Company's Phone:(___)_____

City:_____ State:_____ Zip:_____

Family 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.):

_____

_____

List ALL medication taken on a regular basis and/or any brought with (Prescription meds MUST have pharmacy label and doctor's name:

_____

_____

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

_____

_____

Date of last Tetanus Shot:_____

220 MEDICAL RELEASE FORM
PAGE 2

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 my child. In the event of an emergency and neither the secondary contact nor myself can be reached, I hereby give permission to the physician selected by the participant's Church sponsor/his designee or camp staff to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery for my child as named above. I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do herby, release the below named event, its directors, employees, or agents from liability associated with participation in the below named event.

_____

Name of Event

_____

Signature of Parent/Guardian Date

The following to be completed by the notary witnessing parent/guardian's signature.

The state of _____ the county of _____

Before me, a Notary Public, on this day personally appeared _____

known to me (or proved to me on the oath of_____)

to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this

_____day of _____, A.D._____.

_____

Notary Public, State of _____

_____

Print name of Notary Public here

My commission expires the _____ day of_____, A.D._____.