

PARTICIPANT'S INFORMATION:

NAME: (First, Last) _____		CURRENT GRADE _____	BIRTHDATE: (MM / DD / YY) _____
ADDRESS: _____		CITY: _____	ZIP: _____
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	PROGRAMS ATTENDING (CHECK ALL THAT APPLY) <input type="checkbox"/> WEDNESDAY (Youth, Teens, Busy Bees) <input type="checkbox"/> SUNDAY (Kids Konnection, Sunday School, Toddlers) <input type="checkbox"/> OTHER: _____ <small>(Over Nighters, Kids Camp, Outings, Childrens Chior)</small>	MEDICAL CONDITIONS / KNOWN ALLERGIES (Especially to MEDICATIONS): _____ _____ DATE OF MOST RECENT TETANUS SHOT: _____ / _____ / _____	

PARENT / LEGAL GUARDIAN INFORMATION:

NAME: (First, Last) _____		RELATIONSHIP: _____
ADDRESS: _____		CITY: _____
() ()		ZIP: _____
HOME PHONE: _____	CELL PHONE: _____	EMAIL ADDRESS: _____
Which Social Media sites are you on: <input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> Instagram		
I prefer to receive info by: (NON EMERGENCY) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Social Media		

MEDICAL INFORMATION:

PRIMARY MEDICAL INSURANCE COMPANY: _____	POLICY NUMBER: _____	GROUP OR TYPE NUMBER: _____
PRIMARY CARE PHYSICIAN'S NAME: _____	PHYSICIAN'S PHONE NUMBER: _____	()
OPTIONAL INFORMATION		
DENTIST NAME: _____	DENTIST PHONE NUMBER: _____	()
ORTHODONTIST NAME: _____	ORTHODONTIST PHONE NUMBER: _____	()

EMERGENCY CONTACT INFORMATION:

IN THE EVENT OF AN EMERGENCY, CONTACTS WILL BE CALLED IN SUCCESIVE ORDER.

1	NAME: (First, Last) _____	PHONE NUMBER: _____	RELATIONSHIP: _____
2	NAME: (First, Last) _____	PHONE NUMBER: _____	RELATIONSHIP: _____
3	NAME: (First, Last) _____	PHONE NUMBER: _____	RELATIONSHIP: _____

In my absence, I hereby give my consent and permission for medical transportation and to have a paramedic and/or duly licensed Doctor of Medicine and/or duly licensed Doctor of Dentistry provide my child or legal guardian, a minor identified as "Participant's Name" above, with any and all medical assistance or treatment deemed necessary in the event of an accident, injury, or sudden illness. Further, I authorize admission to any hospital or medical facility for such treatment, including diagnostic procedures performed by licensed technicians or nurses. I authorize the hospital or medical facility to dispose of any specimens or tissue as appropriate. This release is effective until my arrival and it is revoked by me. I agree to be responsible financially for the cost of each transportation, assistance or treatment. I also release Bethany Baptist Church, its staff and volunteers from responsibility and liability for any injury or illness that my child may sustain while participating. I also give permission for my child or legal guardian, the minor identified as "Participant's Name" above, to be photographed or videotaped during activities and allow Bethany to responsibly use these materials for public relations purposes and to be transported to any off-site activities with approved adult volunteers.

The information contained in this form is valid for one year. If any information changes within time frame specified please contact the church office **IMMEDIATELY**.

SIGNATURE: PARENT / LEGAL GUARDIAN _____	DATE: _____ / _____ / _____
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