Lakeside Baptist Church Medical Release Form

Participant's Name: _____ Date of Birth: _____

Address: _____ Today's Date: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ E-mail Address: _____

Allergies (food and drug): _____

_____

Does your child take any prescription medication(s)? _____ If yes, please list: _____

_____

Does your child have any notable medical condition(s)? _____ If yes, please explain: _____

_____

_____

Name of Medical Insurance Company: _____

Insurance Phone Number: _____ Group Number: _____

Policy Number: _____ Name of Primary Insured: _____

In the event of an emergency where medical treatment is required, I, _____ (Parent's Name), give my permission to the staff of Lakeside Baptist Church, or adult sponsor, to obtain the services of a licensed physician in the treatment of my son/daughter, _____. Furthermore, I hereby assume all risk of said personal injury, sickness, death, damage and expense as a result of participation as above set forth. I further hereby agree to hold harmless and indemnify said organization, Lakeside Baptist Church, its directors, officers, employees and agents, for any liability sustained by said organization as the result of the negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

I grant Lakeside Baptist Church and its ministries permission to use my child's name or image in brochures, newsletters, websites, or other promotional materials

If participant is under 21, a parent or legal guardian must sign.

Father's Signature: _____ Cell Phone _____

Mother's Signature: _____ Cell Phone _____

Please list any additional phone numbers where parents can be reached or someone else to contact in case of an emergency: _____

_____