BAY LEAF Baptist Church

# Contact Information/Medical Permission & Release Form

## September 1, 2020 - August 31, 2021

I fully realize that any activity involves a risk of personal injury, property damage, or loss of my person or property. I hereby for myself, my heirs, executors, and administrators, waive and release any claims or rights against Bay Leaf Baptist Church, all of it officers, directors, and coordinators, all owners of equipment which may be used and those who volunteered their equipment, vehicles, and services for any church activity, for any and all injury, damage, or loss to my person or property incurred during a church sponsored activity.

It is my understanding that Bay Leaf Baptist Church will attempt to notify me in case of a medical emergency involving my child. If Bay Leaf Baptist Church staff members, chaperones, or any other Bay Leaf leaders cannot reach me, then I authorize Bay Leaf Baptist Church to secure any medical treatment necessary for my child by any licensed physician or dentist, including the admission for such emergency care to any hospital reasonably accessible. This authorization does not include major surgery unless two licensed physicians or dentists concur that immediate surgery is necessary. I give my permission to the doctor or other health-care professional to provide the medical services he or she may deem necessary. I will accept responsibility for medical expenses so incurred.

(Please print clearly)

Child's Name: _____

Parent/Legal Guardian Name: _____

Address: _____
Street City Zip

Date of Birth: _____ Age: _____ Gender: _____ Grade: _____

Parent/Legal Guardian Telephone Numbers: Home: _____ Work: _____ Cell: _____

Contact in case of Emergency (Relationship): _____
Contact's Telephone Number: _____

Secondary Contact in case of Emergency (Relationship): _____
Secondary Contact's Telephone Number: _____

Insurance Carrier: _____
Member Number: _____ Group Number: _____

Any Medical Problems? Yes_____ No_____
If yes, describe: _____
Medications Currently Prescribed? Yes_____ No_____
If yes, describe: _____

_____ _____
Parent / Legal Guardian Signature Date