

MOB MINISRTIES MEDICAL RELEASE FORM - YOUTH

DATE _____

CHILD'S NAME: _____ BIRTHDATE: _____

ADDRESS: _____ PHONE: _____

FATHER'S NAME: _____ CELL #: _____

PLACE OF EMPLOYMENT: _____ PHONE: _____

MOTHER'S NAME: _____ CELL #: _____

PLACE OF EMPLOYMENT: _____ PHONE: _____

LEGAL GUARDIAN OF CHILD: Father _____ Mother _____ Both _____ Other _____

If other, please give name & address: _____

IF EMERGENCY, AND PARENT'S CAN NOT BE REACHED, PLEASE CALL:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

PHYSICIAN'S NAME _____ **PHONE:** _____

PLEASE LIST ANY:

ALLERGIES: _____

MEDICATIONS: (See back of form) _____

HOSPITAL WITH RECORDS: _____

ANY HEALTH PROBLEMS: _____

DATE OF LAST TETANUS SHOT: _____

PRIMARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Please Attach A Copy Of Your Insurance Card.

.....
I give my permission to any authorized personnel of Immanuel Baptist Church to take emergency measures deemed necessary for the care and protection of my child while under their supervision. In case of accident or illness, I understand that my child will be taken to an appropriate medical facility for treatment. It is understood that in severe situations, the adults in charge may contact the local emergency resource before the parent, child's physician, and other adults acting on the parent's behalf.

I understand that any expenses incurred will be the responsibility of the child's family.

PARENT'S SIGNATURE: _____ DATE: _____

NOTARY: _____ STATE: _____ COUNTY: _____

DATE: _____ MY COMMISSION EXPIRES: _____

NOTE: THIS RELEASE WILL REMAIN IN EFFECT UNTIL JAN. 1, 2007.

MEDICAL RELEASE FORM - YOUTH

DATE _____

YOUTH NAME: _____ BIRTHDATE: _____

ADDRESS: _____ PHONE: _____

FATHER'S NAME: _____ CELL #: _____

PLACE OF EMPLOYMENT: _____ PHONE: _____

MOTHER'S NAME: _____ CELL #: _____

PLACE OF EMPLOYMENT: _____ PHONE: _____

LEGAL GUARDIAN OF CHILD: Father _____ Mother _____ Both _____ Other _____

If other, please give name & address: _____

IF EMERGENCY, AND PARENT'S CAN'T BE REACHED, PLEASE CALL:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

PHYSICIAN'S NAME _____ PHONE: _____

PLEASE LIST ANY:

ALLERGIES: _____

MEDICATIONS: **(See back of form)**

HOSPITAL WITH RECORDS: _____

ANY HEALTH PROBLEMS: _____

DATE OF LAST TETANUS SHOT: _____

PRIMARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Please Attach A Copy of Your Insurance Card.

FATHER'S SOCIAL SECURITY NUMBER: _____

MOTHER'S SOCIAL SECURITY NUMBER: _____

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PARENT'S SIGNATURE: _____ DATE: _____

NOTARY: _____ STATE: _____ COUNTY: _____

DATE: _____ MY COMMISSION EXPIRES: _____

NOTE: THIS RELEASE WILL REMAIN IN EFFECT UNTIL JANUARY, 2007.

SON COUNTRY MEDICAL RELEASE FORM - ADULTS

DATE _____

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ HOME PHONE: _____

CELL PHONE NUMBER: _____

PLACE OF EMPLOYMENT: _____ WORK PHONE: _____

SPOUSE NAME: _____

PLACE OF EMPLOYMENT: _____ WORK PHONE: _____

SPOUSE'S CELL PHONE NUMBER: _____

IF EMERGENCY, AND SPOUSE CAN'T BE REACHED, PLEASE CALL:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

PHYSICIAN'S NAME _____ PHONE: _____

PLEASE LIST ANY:

ALLERGIES: _____

MEDICATIONS: **(See back of form)**

HOSPITAL WITH RECORDS: _____

ANY HEALTH PROBLEMS: _____

DATE OF LAST TETANUS SHOT: _____

PRIMARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Please Attach A Copy Of Your Insurance Card.

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I give my permission to any authorized personnel of Immanuel Baptist Church to take emergency measures deemed necessary for my care and protection. In case of accident or illness, I understand that I will be taken to an appropriate medical facility for treatment. It is understood that in severe situations, the adults in charge may contact the local emergency resource before my spouse or my physician. I understand that any expenses incurred will be my responsibility.

SIGNATURE: _____ DATE: _____

NOTARY: _____ STATE: _____ COUNTY: _____

DATE: _____ MY COMMISSION EXPIRES: _____

NOTE: THIS RELEASE WILL REMAIN IN EFFECT UNTIL MAY 1, 2007.

MEDICAL RELEASE FORM - ADULTS

DATE _____

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ HOME PHONE: _____

CELL PHONE NUMBER: _____

PLACE OF EMPLOYMENT: _____ WORK PHONE: _____

SPOUSE NAME: _____

PLACE OF EMPLOYMENT: _____ WORK PHONE: _____

SPOUSE'S CELL PHONE NUMBER: _____

IF EMERGENCY, AND SPOUSE CAN'T BE REACHED, PLEASE CALL:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

PHYSICIAN'S NAME _____ PHONE: _____

PLEASE LIST ANY:

ALLERGIES: _____

MEDICATIONS: **(See back of form)**

HOSPITAL WITH RECORDS: _____

ANY HEALTH PROBLEMS: _____

DATE OF LAST TETANUS SHOT: _____

PRIMARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Please Attach A Copy Of Your Insurance Card.

YOUR SOCIAL SECURITY NUMBER: _____

SPOUSE SOCIAL SECURITY NUMBER: _____

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SIGNATURE: _____ DATE: _____

NOTARY: _____ STATE: _____ COUNTY: _____

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NOTE: THIS RELEASE WILL REMAIN IN EFFECT UNTIL JANUARY, 2007.