MEDICAL RELEASE FORM

Woodmont Baptist Church Children's Events Dates: January 1, 2020 to December 31,2020

Name:____ Age:___________ SS#___________________

Address:_________________________________ City:_________________ State:________ Zip:_________

In Case of Emergency Notify: ____ Phone: _________________

Family Physician:____ Phone:____________________

Heath Insurance Company: _______________________________Policy Number: _______________________

Policyholder's Name_________________________________ Policyholder's SS#________________________

Immunizations (mark all that apply): ____Tetanus _____ Polio Booster _____ Measles _____Mumps

*** I authorize that my child is permitted to have a non-drowsy Dramamine ______ yes ______no

****

******Please write none where applicable on this section******

ALLERGIES: ____

____

Previous operations or serious illnesses: ____

Current medications being taken: ____

Special Diet:____

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Being the parent or legal guardian of ____________________________, I ______________________________
Do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the Children's Minister, or Chaperone, to make decisions necessary for treatment. Should there be no Children's Minister, or Chaperone, available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

I, the undersigned, do hereby verify that the above information is correct and I do hereby release and forever discharge all sponsors and Woodmont Baptist Church from any and all claims, demands, actions or cause of action, past, present, or future arising out of any damage or injury while participating in any 2020 event.

Dated this ____ day of ______________, 20_____

Parent/Guardian Signature____

State of _________________ County of ___________________

I, the undersigned authority, a notary public in and for said county in said state, hereby certify that
_______________________________, whose name as parent or legal guardian of _________________________
is signed to the foregoing medical release form, and who is known to me, acknowledged before me on this day that, being informed of the contents of said instrument, he/she as such parent or legal guardian and with full authority, executed the same voluntarily.

GIVEN under my hand and official seal this is _____ day of ___________, 20___.

____ My commission expires_______________________
Notary Public

MUST BE 19 YEARS OLD OR OLDER IN ORDER TO SIGN FOR YOURSELF